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Background for Post-war Planning

It is significant that at the opening session of Parliament the Speech from the Throne referred to far-reaching plans for social reconstruction even though the main emphasis was naturally placed upon the necessity of first winning the war. The Canadian Government is evidently convinced that, no matter when it comes, the cessation of hostilities will involve a measure of economic dislocation due to the change-over from a war-time economy. Inevitably there will be repercussions that must be foreseen and guarded against.

Nurses, like all other workers, have been enjoying a period of full employment and, for the first time in some years, there has been more than enough work to go round. Is this happy state of affairs likely to continue or must we brace ourselves to meet the sort of lean years that prevailed between 1930 and 1936? That is the question everyone is asking and that no one can now answer with any certainty. It may be worthwhile, however, to take a look at the principal factors in the situation. The most significant of all is the undeniable fact that, if the full *need* for professional nursing service in Canada were to be met, every Canadian nurse could be put to work tomorrow morning and kept busy indefinitely. There is plenty to be done and we are ready to do it. But the *need* for nursing service unfortunately does not provide a sound economic basis for estimating the *effective demand* for it. The number of nurses employed will be determined by the amount of money that is available for salaries. How much will there be and where is it to come from? That is the real question.

The obvious and easy answer is that health insurance will save the situation by taking up the slack. But even here there is a catch. How long will it be before health insurance actually gets under way? The more optimistic estimates range from one year to ten and imply that there may be a time lag. There are even a few pessimists who think that it will be several years before

health insurance projects can be organized on a broad enough scale to offer employment to any very large number of nurses. The plain truth is that while we are justified in expecting great things we cannot yet be sure of getting them. A good working philosophy is to hope for the best and prepare for the worst. Then, no matter what happens, the required adjustment is more easily made.

At this point it might be worthwhile to touch lightly on one or two somewhat disquieting possibilities. Although no detailed statistical information is available it is apparent that there has been a large increase in the employment of practical nurses, ward aids and other non-professional workers, not only in private homes but also in hospitals. These women have proven themselves extremely useful and without them some institutions, especially sanatoria and mental hospitals, would have had to close their doors. Whether we like it or not, the public wants the sort of service these women are able to give and they are in the nursing field to stay.

Another factor that is of some importance lies outside Canadian jurisdiction. By means of the recently organized Student Nurse Cadet Corps, the United States is increasing enormously the output of graduate nurses from American schools. When the war is over these young women will be ready to enter the competitive professional field. Well informed leaders of American nursing are confident that there is no danger of flooding the market since all will be needed for post-war reconstruction either in the United States or in other parts of the world. But there are a few dissenters who are not so sure. In any event, it is well to remember that the American border has been closed to Canadian nurses before and that it may be again. Canadian nurses may be in demand in the United States after the war. But they may not. Better not count on it too much, anyway.

Having taken a good look at the troubles that may beset us we can now glance at the brighter side of things. The Canadian Nurses Association and its provincial units are in a sound and prosperous condition, with young and competent women at the wheel. There has been an increase in student enrolment but not to an extent which threatens to flood the market. A generous grant from the Federal Government has made it possible to carry out some excellent educational projects. Carefully selected young nurses have been given an opportunity to undertake postgraduate study and thus to prepare themselves for the tasks which lie ahead. A realistic approach has been made to the use of collective bargaining as a defence against insufficient salaries and unfair working conditions. All this is very much to the good.

To show that it is thoroughly aware of the trend of the times, the Canadian Nurses Association has already appointed a Committee on Reconstruction on which a wide and representative membership is to be assured. This committee will immediately explore all possible avenues of employment and will map out the paths by which nurses may be directed into them. There can be no doubt that some of these avenues will lead us into much broader fields than we have ever previously enjoyed. There will be no need to cling to routine duties which can be done just as well, or even better, by less well prepared workers. Much more challenging tasks await us and will be met by an unwavering determination to show ourselves competent to deal with them.

The awakening of a social conscience in the people of Canada will bring about reforms that will make us wonder how we ever endured the evil days of indifference and neglect. There's a good time coming. Don't believe anyone who says there isn't. —E. J.

Appendicitis in Childhood

EDGEWORTH MURRAY

We realize with the passing of the years that life in our hospitals is made up of continuous change, but the subject I wish to discuss in this brief paper is a condition which has brought grief in the years gone by, and is not declining—namely, acute appendicitis in childhood.

A great many people, apart from the medical profession, do not recognize how difficult the diagnosis of acute appendicitis is in childhood, and it goes without saying that one cannot compare children and adults in making this diagnosis. Rheumatic fever, gastro-enteritis, lobar pneumonia and measles in the child will often give the same symptoms as an acute abdomen — vomiting and abdominal pain, sometimes sharply localized tenderness in the right lower quadrant, involuntary spasm over the lower abdomen and rectal tenderness. The leucocyte count may show a high preponderance of polymorphonuclears, the urine may be normal, the temperature elevated and the pulse rate rapid. The skin may be dry and hot and the facial expression anxious. Often, in the very young, an acute abdomen may give rise to all these symptoms plus grunting respirations. Then again the temperature may be normal, with no abdominal symptoms as in a gangrenous appendix. The age of the child increases the difficulty of prompt diagnosis.

The peritoneum is more often involved in children than in adults. The younger children — those under five years — have a graver prognosis. We have observed nine-months-old infants suffering from ruptured and acute gangrenous appendix. A case is on record of acute perforative appendicitis in a twenty-day-old infant. Dr. Rowland W. John, of Cardiff, reports a premature twin girl, 16 days old, dying one day after development of severe melena; although rectal temperature had not risen above 98 degrees and no abdominal signs had appeared, autopsy revealed acute gangrenous appendicitis with peritonitis.

Acute rheumatic fever and lobar pneumonia are not infrequently ushered in with complaints of severe abdominal pain, even in children 10 and 12 years old. It is therefore not to be wondered at if, on rare occasions, the appendix is found to be normal and the surgeon on his return from the operating room says: "Watch that child for further symptoms — it was *not* appendicitis". An alert nurse can greatly assist the doctor in his diagnosis. Most children look flushed and anxious during an acute attack, but then again many appear in perfect health. A great number of children deny pain. Many acute cases have normal or slightly elevated temperatures, and only slight change in the pulse rate.

In general hospitals, student nurses often find difficulty (due to their short training in the children's ward) in taking children's pulses and realizing their significance. The abdominal findings cannot be over-stressed and the nurse who realizes the importance of the correct posture of the patient during the examination will greatly assist the surgeon in making a satisfactory diagnosis. During the examination, the child must be reclining with head and shoulders slightly in Fowler's position (equal to two small pillows) in order to relax the abdominal muscles. The knees should be slightly flexed and the arms should be lying in a relaxed state at each side, but not touching the body.

The white blood cell differential

count and the urinalysis should be obtained immediately upon admission so that the surgeon may be promptly informed. The examiner will wish to have a warm hand, and will pass it gently and lightly over the entire abdomen and loins, estimating the resistance of the muscles. Later, after deciding the state of the muscles, tenderness may be gently sought on palpation. If there is any question of an acute abdomen the alert nurse, realizing the dangers of activity on the part of the patient, will give gentle and prompt nursing care, moving the patient as little as possible as the early symptoms are often misleading, and the last thing a little child who is really ill does is to complain.

The R.C.A.F. Nursing Service

All over Canada, and especially on the prairies, there are vast establishments about which very little can be told. They belong to the Royal Canadian Air Force and from them come the men who are writing the name of Canada in flame in the dark skies over Germany.

More than three hundred Nursing Sisters are now on duty with the R.C.A.F. in Canada many of whom are attached to small medical units that usually include a thirty-five-bed hospital. Most of these stations are in isolated areas and have a relatively small staff of Nursing Sisters who, while they cannot give all the bedside care that is required, are responsible for supervising the hospital assistants and other auxiliary personnel thus making certain that the safety and comfort of the patients are assured.

MATRON JESSIE PORTEOUS

In case of a crash or other accident the Nursing Sisters must be self-sufficient in a fashion rarely encountered in the other Services. The Medical Officer will be at the scene of the crash and the nurse must direct all activity in the hospital and make sure that everything is in readiness when he arrives with the patients. Her ingenuity and resourcefulness are constantly brought into play for she has no matron or supervisor to whom she can appeal. Her assistants are willing and anxious to help but they may become alarmed and excited. They look to her for guidance and she must therefore remain "calm, cool and collected" at all times and under all circumstances.

In order that such emergencies may be met promptly and efficiently, the Nursing Sisters are selected carefully

Official Photograph, Army Air Force

General Grant, Lt.-Col. Close, Matron Porteous with six R.C.A.F. Nursing Sisters (Hardwick, Pinckney, Jordison, Collings, Labrèque and Lack) who had just completed their course at the American Army Air Force School of Evacuation.

and are given special training. The larger R.C.A.F. hospitals are equipped with very fine operating rooms and the Sisters-in-Charge have been operating-room supervisors in civilian life. Nurses who have already had some experience in surgical nursing are assigned to these units for instruction before they are sent out to take charge in the smaller units.

Shortly after they join the Service, the Nursing Sisters attend the School of Aviation Nursing in Toronto where they learn about R.C.A.F. organization and administration. They are also taught something about the physiology of flying and the course is now being modified in such a manner as to place more emphasis on this subject. Physical training and calisthenics also form an important part of the course.

Matron Jessie E. Porteous is in charge of the administration of the Nursing Service and is stationed at Air Force Headquarters in Ottawa. In addition, other Matrons are in charge of the larger R.C.A.F. hospitals throughout Canada. Matron Porteous is a graduate of the School of Nursing of the Saskatoon City Hospital. She has taken the course in administration in hospitals and schools of nursing offered by the McGill School for Graduate Nurses as well as a postgraduate course in tuberculosis treatment and nursing in the Saskatoon Sanitarium. Keenly interested in teaching, she served for two years as instructor in the School of Nursing of the Saskatoon City Hospital and, at the time that she joined the nursing service of the R.C.A.F., was assistant director of nursing in that hospital. She is fond of riding and skating whenever she can find time in her busy life for recreation.

Matron Porteous is of the opinion that nurses who have had postgraduate courses or practical experience in teaching and supervision, ward administration or public health, are particularly valuable. She is very appreciative of the fine work done by Sisters who are alone in isolated stations and who have cared for dangerously ill patients day and night for a week or more. "None of this is glamorous but is just what we must expect in certain circumstances" is the way she puts it. They just rise to the oc-

R. C. A. F. Photograph

A patient is placed on a transport plane under the direction of the R.C.A.F. Medical Officer and a Nursing Sister.

casion like the fine Canadian nurses they are.

A recent development which has international implications is of great interest. Six R.C.A.F. Nursing Sisters have just returned to Canada after attending the School of Air Evacuation at Bowman Field, in Kentucky, U.S.A. A member of this group, Nursing Sister Emma Jordison, tied for first place in a class of ninety-four nurses from all over the United States and Canada. She is a graduate of the School of Nursing of the Toronto General Hospital and has taken a course in teaching and supervision at the School of Nursing of the University of Toronto.

Upon the successful completion of the course, the entire group became qualified Flight Nurses. Since returning to Canada they have been stationed at R.C.A.F. hospitals where their services are being utilized in air transportation of patients. The Douglas Transport lends itself very well to this type of work and is the plane most commonly used by the American Army Air Force for evacuation purposes.

In addition to the members of the Nursing Service who are on duty in Canada twenty-two R.C.A.F. Nursing Sisters are already serving overseas some of them with the R.C.A.F. Bomber group and others with Royal Air Force personnel.

No matter where their duty takes them it is certain that the R.C.A.F. Nursing Sisters will give an excellent account of themselves and will prove to be worthy of the Service with which they have the high privilege to be associated.

Fever Therapy in Gonorrhoea

R. M. MacDonald, Surg. Lieut., R.C.N.V.R.

Fever therapy is one of the oldest forms of treatment having been practised by the ancient Greeks, Romans and Chinese with their hot baths and "sweating houses". In 1876, Rozenblum of Odessa reported the intentional production of relapsing fever in psychotic patients. Little notice was taken of this until Wagner-Jauregg introduced malaria fever as a therapeutic agent in neurosyphilis in 1918. His results definitely showed that beneficial effects were produced and it was subsequently proven that these results were due to the fever rather than any beneficial effect of one disease counteracting another disease. Since then there have been many reports of different types of fever-producing agents in the treatment of many diseases. The use of typhoid vaccines, protein injections, hot packs, hot baths, diathermy and many types of heating cabinets have all had their supporters. The most popular method in this country for carrying out long sessions of high fever is the hot, humid air cabinet such as we are using at the Camp Hill Hospital. We feel that it is the most satisfactory type of apparatus for our work but workers in this and other countries have obtained good results with other methods in which they have had extensive experience.

Neyman, a pioneer in treatment by artificial fever, considered 1927 to 1932 the experimental stage. In the following five years, there were an increasing number of cabinets in use and workers were reporting 80% to 90% cures in the treatment of gonorrhoea. About this time the sulfonamides came into general use and were such a great advance that fever therapy was relegated to a minor role in gonococcal infections. After the first wild enthusiasm for chemotherapy had settled down, it was found that there was a 15% to 40% group of cases which were resistant to one or all of the sulfonamides. In addition, an increasing number of people are becoming toxic to these drugs. Realizing this, the armed forces of this country and the United States have been responsible for instituting a large-scale fever therapy program to help overcome the number one cause of man-days lost in the armed forces. We are all looking forward to the near future when penicillin will be in general use and when the only gonorrhoea cases requiring fever therapy will be the few who are resistant to both sulfonamides and penicillin.

This modern advance will not see the end of fever therapy as there are still a large number of cases of neurosyphilis throughout the country requiring treatment. Krusen states there are over fifty diseases which have been treated by fever therapy. In most of these it has been of little or no use but rather an attempt at treating diseases of which medical science has little to offer at present. There are several diseases in which its efficacy has yet to be proven but in undulant fever and Syndenham's chorea (St. Vitus dance) it is of definite help. In our clinic we are treating a few neurosyphilis cases but the bulk of our work is gonorrhoea and its complications. Our cabinets are relatively simple in design and look like an artificial respirator with only the head protruding. Below the mattress there is a heating unit, fan and wick towelling leading into a pan of water. By turning on the buttons, hot, moist air is circulated through the cabinet and the temperature of the air about the patient is registered on a thermometer coming out of the cabinet.

Doors on the sides allow for nursing attention and frequent rectal temperature readings.

We have treated about 100 gonorrhoea cases since our clinic opened in August. We are having about 95% apparent cures which is considered satisfactory in this type of case. About 75% of cases obtain a cure with one treatment while the remaining ones have two or three sessions of fever. A treatment is usually seven hours at over 106 degrees. In contrast to these, the neurosyphilis cases are given about a dozen weekly treatments for a total of 70 hours over 105 degrees.

Having mentioned the types of cases we treat, I would like to speak of the part which is of more interest to nurses; namely, the actual administration of the treatment. I shall refer only to the gonorrhoea cases. The selection of the patient naturally is the responsibility of the doctor and each case is very much of an individual problem. These patients have to be considered as carefully as ones for a major operation and the cardiovascular and urinary system receive our particular attention. Normally, we have them in hospital for two days before treatment for investigation and premedication. They receive salt capsules and extra fluids to counteract loss due to sweating. If they are not toxic to the sulfa drugs, they are given 90 grains of sulfadiazine in the 12 hours preceding treatment. The reason for this is that the results of fever therapy plus sulfonamides are better than fever therapy alone.

The evening before treatment an enema is administered. The patient is allowed a very light breakfast before being placed in the pre-heated cabinet. He has no coverings other than terry cloth leggings to ease the heat effects at the foot of the cabinet, and a jockstrap which makes the frequent rectal temperature recording less embarrassing for the patient. When the cabinet is closed and towelling adjusted about the neck, the cabinet is about 125 degrees. The first hour and a quarter, which is the usual period needed to raise the patient's temperature from normal to 106 degrees, is called the induction period. It is the hardest part of the treatment for the patient and often for the nurse as well. It should not be less than one hour in the interest of safety, or more than one and one-half hours in the interest of the patient's comfort. During this period, he may have subjective feelings of being hot, weakness, headache, heart pounding, and a sensation of difficulty in breathing. It may seem strange to you, but when we level the patients' temperature at about 106 degrees, they almost invariably tell you they are better and many will say they are feeling fine. The art of controlling the temperature of the cabinet by means of the heater switches and regulating them so that the temperature of the patient settles between 106.4 degrees and 106.8 degrees is one which requires considerable training and judgment. We aim at running a patient at about 106.6 degrees for seven hours and cases vary in their ease to be kept at a steady temperature. The ability of the nurse can be judged by her temperature charts.

During the long period of pyrexia, the nurse is on constant vigil and gives close attention to her patient. She takes rectal temperatures at five-minute intervals and frequent pulse recordings. She supplies him with frequent small drinks and applies cold cloths to his face and forehead which has a fan playing on it. She has to set up and maintain the running of the intravenous glucose saline drip that is administered during treatment. In addition, 50% glucose is given intravenously at intervals. Periodic administration of oxygen is carried out by means of a nasal mask. There are many other duties to be performed and one of the most important is to be able to talk, amuse, reassure or otherwise assist the

patient through his trying moments. It is in this type of duty that the fever therapy nurse shows her worth and if she fails here then she is useless. To do the mechanical part with ability is not enough if she has not sympathy, understanding, and above all, patience. To lose one's temper is to lose the patient's co-operation and the treatment may have to be terminated. All of you have worked with delirious, fevered patients and know how difficult they may be. It does not require much imagination to understand the added difficulties if they are in a cabinet with an intravenous drip set up. Some patients are mentally clear throughout treatment, while others may be delirious, restless, noisy or comatose. Most of our patients get some sedation during the induction but these drugs are not without danger and most doctors will agree that an efficient and understanding nurse is the best sedative.

If a patient coasts above 107 degrees, he is in immediate danger. Cardiovascular collapse should be anticipated by the appearance of the patient and the rate and quality of the pulse. Complications such as severe delirium, marked restlessness, convulsions, or further elevation of the temperature may necessitate the immediate discontinuation of treatment. Most of these decisions are those of the doctor who is on constant call during treatments but the nurses are given perfect freedom to take a patient out at any time if an emergency suddenly arises. They are familiar with the administration of any emergency measures which are required. We have had our worrying complications but they have not been numerous and it is seldom that we have to take our patients out early.

Perhaps my remarks have stressed the dangers of fever therapy. True, they are always present and you are constantly in a state of some tension as, figuratively speaking, you are working at the edge of a volcano, but heroic as the treatment is there are few of our patients who are unable to stand it. In a well run clinic, it is a routine every-day procedure but one which should never be attempted unless it is carried out under trained supervision where the workers are prepared to treat any emergency immediately. Even in such a place there is a potential danger, which should be practically negligible, but inefficiency on the part of any member of the team makes real danger an ever-present possibility. We usually give a seven-hour treatment and the last one or two hours may be difficult because the patient finds the time so long and often feels he is being fooled on the time. Sometimes the remark that the nurse is just as anxious to be finished and to get home is the rapid cure for this delusion.

When the treatment is finished, the cabinet is opened and the patient has a fan on his body. It takes about one hour to come down to nearly normal temperature. Patients are given a bath before being returned to bed. On return to bed, they are allowed fluids as desired if there is not marked vomiting but few are anxious for food before the next morning. Some nausea and vomiting is a common occurrence but sometimes it is considerable and requires intravenous glucose saline to make the patients more comfortable. Most patients are up and about the following afternoon and if they are free from discharge, their urine is satisfactory, and they have negative smears on the second, third and fourth day they are ready for discharge as apparent cures. If a cure does not result, the patient has a repeat treatment after a three or four day interval. Herpes about the lips is a frequent complication appearing about the second or third day after treatment but it is seldom serious. A few small blisters, chiefly on the toes, are not infrequent but they are not troublesome.

Having heard about this rather heroic method of curing a disease, you might well ask, "how does the patient

react to it?" Most of them say that it was pretty grim and that they will not forget it for a long time. They are however grateful patients, and are our best advertisement; so much so, that patients not responding to ordinary therapy methods in the venereal disease wards are asking their doctors to send them for "hot-box treatment".

In conclusion, I would like to say that as a doctor responsible for these patients, it is a pleasure to work in a clinic where one sees what I consider the most trying and nerve-racking form of nursing being carried out efficiently. The satisfaction of seeing dramatic results and having the sincere thanks of the patient is just reward, and makes up for those moments which all fever therapy nurses have at some time when they say to themselves, "Why did I ever take up fever therapy nursing?"

All in the Day's Work

I have moved on again from where I was. It is quite impossible to get anything in the way of trunks or suit cases, so I had my few possessions in what looked like a basket for carrier pigeons and a dog basket; also, a roll of blankets and the usual gas-mask. The trains are very sooty and there isn't much water. The journey took 52 hours, including two nights, so I got down at my destination black all over and hugging my baskets.

It's rather awful, especially when wearing different clothes from everybody else and not having any of the right eqiupment like camp kit, baths and stoves. I had to explain to a harassed Matron when I arrived that I was known as a "survivor" and should be grateful for a bed. One Sister even said "Oh! were you torpedoed?" I was so tired I just said, "Well, try sitting, while seasick, in a full life-boat for eight hours with the ship sinking behind you. It's quite nice!" and she looked really hurt. Actually, it's the absence of handkerchiefs, needle and cotton and things like that that get you down after a bit. It did not matter at my last hospital because we were all in the same boat, but I get so tired of being in the wrong place at the wrong time and saying to a strange Matron "I am so sorry, my watch has stopped. It got wet".

Now I have the one job I wanted in the Army — sister-in-charge of a Mobile C.C.S. I arrived at midnight alone after a 700 mile journey by various army conveyances through gorges and mountain passes. As we got nearer the battle fields we saw lots of German graves by the roadside and masses of burnt-out planes and tanks. Some of the roads were fairly awful — what with bomb and shell-holes or having been raked with machine-gun fire. At some points there were notices to say "Mines cleared on either side, 10 yards", or "Mines in verge, keep to centre of road." Some parts of the road hung over mountains, and a drop would have been thousands of feet. My four Sisters did not come for three days and I was the only woman for twenty miles around. My tent was pitched a bit away from the officers' lines, and my only view, the war cemetery.

The second day I was here, a casualty was brought in — a gunshot wound of the abdomen. We put the patient straight and when we had him clean and tidy, there was a sudden roaring rush. Everyone dashed to fasten canvas windows and doors. Imagine the whole of you in a hot electric hair-dryer which is blowing sand into your eyes, ears, nose and mouth and you will know what the next half-hour was like.

I have just upset someone else's ink over my camp chair and, jumping up to rescue it, I trod on a huge spider. I think we should have a "hardship ward" after the war, full of primuses that don't work, torrential rains, sirrocos, scorpions and spiders.

Editor's Note: These amusing comments are quoted from letters from Nursing Sister C. Ellis, Q.A.I.M.N.S., published in The Nightingale Fellowship Journal.

Recent Advances in Hematology

S. R. Townsend, B.A., M.D., C.M.

During the past few years great strides have been made in the study of coagulation of blood. Much knowledge has accumulated and has found immediate clinical application. The body has a dual defense against hemorrhage, the first being the coagulability of the blood, and the second, the vascular response to trauma and injury. Space does not permit a discussion of this whole question, but something will be said about the first defense mechanism against hemorrhage, namely the coagulation of the blood, and the counterpart of hemorrhage, intravascular clotting and its relationship to this mechanism of coagulation. There is sufficient evidence to allow one to express blood coagulation concisely in the form of two equations: prothrombin plus thromboplastin plus calcium equals thrombin; fibrinogen plus thrombin equals fibrin (clot). Obviously a deficiency of any one of these will wholly inhibit or markedly delay the coagulation of blood. On the other hand, it is not known what disturbance will produce a stimulus to intravascular clotting or increase in the coagulability of the blood.

Several clinical entities always have been a source of worry to the clinician and surgeon: (1) the hemorrhage, often fatal, occurring in patients with obstructive jaundice; (2) certain cases of hemorrhagic disease of the newborn; and (3) the occurrence of thrombophlebitis, post-operative pulmonary embolism, or other infarction which is often fatal. The observation that cattle, fed on improperly cured sweet clover, developed a hemorrhagic disease which can be cured by feeding alfalfa, led to an investigation of the substances in rotted sweet clover and in alfalfa which were responsible for these effects. The practical application of these substances, dicoumarin and vitamin K, to problems in clinical medicine and the control of the physiology of the human being has developed rapidly. As a result of these studies, much is now known of the role of the fat soluble vitamin K in the production of prothrombin in the hemorrhagic diathesis of man associated with biliary fistula and obstructive jaundice. Vitamin K, a naphthoquinone, is abundantly found in alfalfa, spinach, and certain other vegetables. It has been demonstrated that this vitamin is necessary for the formation of prothrombin. Lack of vitamin K may be a result of deficiency in the diet, absence of bile from the gastro-intestinal tract by reason of obstructive jaundice or biliary fistula, and in cases with liver damage. For the absorption of vitamin K from the intestine, bile salts are necessary. If bile is lacking, as in obstructive jaundice or when there is a biliary fistula, K deficiency and hypoprothrombinemia result. There being an excess of prothrombin normally, bleeding does not occur until the prothrombin content of the plasma is reduced to less than 20% of normal.

Hemorrhagic disease of the newborn, characterized by spontaneous external or internal hemorrhages and an exceedingly low prothrombin concentration in the blood, is also benefited by vitamin K therapy. Treatment of hypoprothrombinemia from any of the various causes can now be treated by intramuscular or intravenous administration of synthetic naphthoquinones. Bile salts are unnecessary unless the preparations are given orally.

The hemorrhagic disease occurring in cattle which have been fed spoiled silage, made from spoiled sweet clover, also reveals a hypoprothrombinemia. The

toxic principle in the spoiled hay, a dicoumarin compound, has been isolated and synthesized. This product, when given by mouth, produces an anticoagulant effect which may prove useful in the treatment of thrombosis and pulmonary embolism. Reports reveal, in thrombophlebitis for instance, that as the prothrombin content falls in treated patients it is accompanied by clinical improvement, as shown by a fall in temperature and diminished congestion of the leg. Others have shown that the expected incidence of subsequent thrombosis and embolism has been decreased.

There are no apparent ill effects from the use of the dicoumarin compound, but major and minor bleeding may occur and blood transfusion must be utilized to control the induced hemorrhage. Since little as yet is known of the pharmacology and physiology of the drug's action, the compound should be used with caution. The drug should not be used in patients who are bleeding, or in whom tests have shown a tendency to bleed. It is particularly dangerous in subacute bacterial endocarditis where there is already a tendency to bleed. Patients should be hospitalized where prothrombin studies can be made and dosage of the drug controlled.

The record of the development of these products forms one of the most dramatic stories in the field of therapy. These are only a few of the practical results of recent knowledge but serve to show that progress is being made in this important field. It is now possible to develop a clinical classification of the hemorrhagic diseases based on the theory of blood coagulation stated previously. Thus the approach to the study of these various diseases has been opened so that one may hope for complete insight into and treatment of these little understood conditions in the near future.

Smart Uniforms and Bright Ideas

It appears that the members of the Indian Military Nursing Service wear a very smart uniform which is smoke blue with Indian Empire blue facings. Judging from the stories told in a recent issue of the Nursing Journal of India they also have some very bright ideas. Here is one sample: "This place is hot, and cursed with terrific sand storms. Just as I was pulling on my dear old yellow bathing cap, in preparation to run for a much needed shower, the precious thing split from front to black. There I stood with two limp bits of rubber in my hands and not another bathing cap this side of Bombay. My heart sank. I wanted that shower and there was no time to get my hair wet. Then came a bright idea. Why not use my tin hat? It could shed water as well as shrapnel. Down I pulled it from its perch, and off I trotted. Giggles and mirth on all sides greeted me. But, would you believe it, by to-day all the staff have copied me!"

Then there was the Sister who solved the problem of water supply in a simple and eminently practical fashion: "If you are having trouble getting clear water out of the green scummed pools you come across, I have a bright idea about that. Let me give you a lesson. Get to the best place you can where the water is rather deep. Roll up your sleeves to your shoulders. Cork your bottle and, keeping it corked, push it down into the water as far as you can. The green slime feels nasty on your arms, but don't think about it. Then, take out the cork and let it fill with the water that is two or three feet below the surface. When you bring it up you'll be surprised how clear and sparkling it is. Of course you mustn't get into the mud at the bottom of the pool. Get the water that is in between the mud and the scum. It makes grand tea".

When it comes to resourcefulness and a capacity to improvise you can't beat the British Commonwealth of Nations.

The Problem of Crush Syndrome

It is a curious fact that this war has produced many medical and surgical problems which were almost unknown before September 3, 1939, and crush syndrome comes under such a category. It is true that German doctors were familiar with the condition in the last war, and this is probably due to the fact that they were much more thorough in their investigation of their badly crushed cases from the biochemical point of view.

After four years of total warfare quite a number of crush injuries have been investigated very thoroughly in this country (Britain) and new light has been shed on the pathology of the condition. It must be admitted that many severely crushed persons have died after the heavy air raids in 1940-41, but few of these were fully investigated from the biochemical point of view. As a general rule, the typical case of crush syndrome is not spotted until signs of renal failure have developed, therefore, it is essential that the medical and nursing profession should become "crush syndrome minded" with every case in which a limb has been subjected to pressure for some time.

To give an example: An A.R.P. warden on duty during the blitz of a South Coast town was pinned by both legs beneath a heavy iron girder after a bomb had demolished a large shop. As far as could be ascertained he was trapped for some ten hours before rescue. On admission to hospital both legs were swollen and the thigh muscles appeared engorged and tense, and there were multiple blisters in areas where the girder had impinged on the limb. These, at first sight, were thought to be due to burns, but there was not a sign of burns anywhere else and they were, therefore, due to trauma. Forty-eight hours after the accident both lower limbs were pale and cold and no pulsation could be made out. Elevation of the limbs did not improve the condition. The outflow of urine gradually diminished, although the intake of fluids by mouth was quite good. The urine contained albumin, granular casts and some pigmented granules. Vomiting commenced on the fourth day and this was followed by abdominal pain and rigidity. Death occurred quite suddenly on the sixth day, in spite of treatment in the shape of large doses of sodium citrate to produce an alkaline diuresis. This case, which is typical of many, demonstrates the fact that every ounce of urine a crushed patient passes must be kept and carefully investigated. We have enough evidence from autopsy examinations on fatal cases to prove the important fact that the renal tubules are grossly damaged, and often contain certain brown pigment. The glomeruli do not show any obvious structural change.

An examination of the crushed muscles simply reveals a very advanced necrosis. The pigment in the urine and presumably in the tubules has been proved to be identical with myohaemoglobin. It is possible, therefore, that the myohaemoglobin may produce renal failure by blockage of the tubules. Some interesting animal experiments have been performed to support this interesting theory regarding myohaemoglobin. In the rabbit, whose muscles do not contain any myohaemoglobin, experimental muscle necrosis produces all the signs and symptoms of crush injury with the important exception of no myohaemoglobin in the urine and no renal failure. If, however, some myohaemoglobin is injected into a rabbit and acidified with ammonium chloride, death follows from renal failure.

The things that matter in these crush cases are the actual amount of muscle necrosis present and the length of time the pressure on the limb is exerted. In

some cases there are multiple injuries which help to confuse the issue. Also shock is invariably present and calls for treatment. Repeated examinations of the urine are necessary in a case of suspected crush syndrome, as it is important to verify the presence of albumin, casts and pigment as early as possible so that adequate treatment may be given. The blood urea rises, so does the potassium and phosphate concentration. The blood pressure also rises to a high level. It is important not to wait until all the signs of renal failure are evident before commencing treatment, otherwise a fatal issue will be common.

It is essential that the fluid intake of alkaline fluid by mouth should be at least three litres daily, so that a definite diuresis is produced. If it is impossible to get this amount of fluid taken by mouth the intravenous route must be used. Sodium citrate or bicarbonate up to 50 grains a day should be given and not the potassium salts. This treatment must be continued until the urine is quite normal in consistence.

It is curious to think that many a man or woman with a severely damaged leg or legs has recovered after amputation, and yet a less severely damaged case has died of "crush syndrome". As the medical and nursing public becomes familiar with this condition, the prognosis will certainly improve and few fatal cases will occur.

Editor's Note: This article originally appeared in the "Nursing Times", Oct. 2, 1943.

Faithful Service

There recently retired from the nursing service of the Vancouver General Hospital, one of those members of the profession who by their quiet but forceful attitude demonstrate to the community that priceless quality — faithful service. Olive Shore, for whom so many of her colleagues have such a deep feeling of affection and admiration, graduated from the School of Nursing of the Vancouver General Hospital in 1918. Since that time she has successively held the positions of head nurse, instructor and assistant executive. In the latter capacity she served as the faithful and true "second-in-command" with three different directors of nursing — an achievement that speaks for itself and that contributed enormously to the smooth running of a very busy and active institution. Miss Shore will be remembered by the Alumnae Association, the nursing staff and the students for the fair, fearless and loyal support given to her Alma Mater over a period of twenty-five years — years that were fraught with many changes and problems. She symbolizes the nurse who, under *all* conditions, always measures up! Her many friends wish her all happiness and good health in her retirement.

OLIVE SHORE

HOSPITALS & SCHOOLS *of* NURSING

Contributed by the Hospital and School of Nursing Section of the C. N. A.

The Challenge of Materia Medica

MARION MYERS

Drug therapy is one of the oldest forms of treatment still in use. Rich in historical background, it has been associated with the art of healing down through the ages, and even today it can be seen in primitive, ancient and scientific situations according to the mental progress of man. In such countries as our own, where science gradully lifts from our minds the veil of mystery and shows us "the why", materia medica readily adjusts to a changing world and associates itself even more closely with chemistry than did the older materia medica with magic — the strong power of its day. Thus it continues to play a leading role in the art of healing and consequently claims an important place in the nursing school curriculum.

Due to its close association with chemistry, materia medica cannot but be on the move more especially today when big business on a competitive basis has formed a strong alliance with the drug laboratory. The result is that new preparations are rapidly placed on the market, each with a new and intriguing name, completely obliterating its origin, but capable of keeping it before the public and the medical profession, until its popularity is challenged by the release of something new. This factor alone increases the difficulties in teaching this subject. Text books cannot possibly keep pace with the constant march of new preparations across the stage of drug therapy.

To quote from the Weir Report: "An accurate elementary knowledge of the main drugs and their reactions is obviously desirable in the education of a nurse. Her chief need is a reference knowledge of the field rather than a memoriter grind which is soon forgotten. Competent students should be enabled, during the period of classroom instruction, to receive sufficient basic training to suggest avenues for further study as need arises". How prophetically Dr. Weir has written. The change in the content of this subject has been most marked since his report was published in 1932, and definitely demands an appreciation of the need for continuous study and research, so constantly has it been exposed to experimentation and change.

In hospitals associated with training schools, student nurses (often during their first year) administer these dangerous substances. Although the rules for their administration seem well covered in our order books, charts and medicine cards, the student still experiences many perplexities, especially at night in the absence of the head nurse or when

interpreting the order of a young houseman. In the latter case, experience and tact seem the best means of guiding the administration toward the protection of both the patient and the doctor.

Materia medica, along with other subjects in the curriculum, still suffers from poor relationship between theory and practice. When it is taught in the first year, its clinical application is not well appreciated although it can be greatly reinforced and better established by the study of physiology and at the same time saved from becoming a parrot-like repetition.

Before proceeding further the following facts might be summarized:

1. Materia medica will, in spite of its correlation with other subjects, continue to impose a tax on the memory rather than on reasoning if correct dosages are to be appreciated.
2. Text books cannot cover this subject adequately at any one time.
3. Hospitals vary greatly in their choice of similar drugs.
4. Materia medica, although dropped as a classroom subject after the first year, must be presented clinically from time to time during the second and third years.
5. Materia medica cannot be truly appreciated apart from an understanding of pathology.
6. It seems most necessary that nurses learn to appreciate the need for continuing to follow the moving trend of this science and receive guidance regarding means of obtaining information.

I should like to suggest a few means of meeting the points I have already enumerated. The usefulness of the text must be built up; the fact of its uncontrollable inadequacy induces the student to supplement it herself and this very act makes the book a more familiar reference channel. Blank pages would be helpful here in filling the missing links between editions as well as providing space for local items.

The student can also make good marginal notes and underline material relative to its application in the home hospital. It seems useless to continue the study of individual preparations beyond this point, and more time could profitably be spent in an attempt to make her familiar with what is being used on the wards. If this is really accomplished, she has something on which to base further information. A small loose-leaf note book, kept exclusively for this purpose, is a method favoured by many. Other students build up remarkable scrap books of drawings, pictures and magazine references, as well as excerpts from commercial literature relative to the most salient points in the drug story.

The memory reserves may be greatly reinforced through that time-worn yet psychologically sound method of repetition. This may be done in various ways, such as completing information when no key is given, scoring tests as demonstrated by Faddis and Hayman in Pharmacology (unit plan) and, for variety, and oral quiz something like "Share the Wealth" is not to be looked down upon. This has endless possibilities during the latter part of the course.

To stimulate the use of the text, it is well occasionally to permit its use at tests. This is time-consuming and the student loses out if it has to be referred to much, but correct written information is one more stamp on the memory cells. These tests might count for a certain percentage in the final examinations. At the beginning of the course inform the students of the test system as a means of evaluating her daily knowledge and no further notification is necessary.

Keep a place in the library for a materia medica cabinet; for this it is easy to procure drugs and drug containers used in the hospital. Mount the tablets, pills and capsules on medicine cards, label them with the trade name (if this is best known) and if possible the active principle and dosage. Keep these in small

envelopes made of cellophane or bleached x-ray film, made by stapling two small pieces of the required size together; this makes a very substantial and transparent cover. Sealed ampules may be kept in the same way. (We also use these covers for medicine cards on the wards).

For serums, hypodermic tablets and large or expensive vials, keep the empty containers; these are very informative and may be changed often without expense. I would suggest grouping these substances according to use; for example, a group like the haematinics presents a variety of mineral, glandular and vitamin preparations. In this collection of drugs and empty containers I would also include well organized references and commercial literature. Medicine cards, mounted and containing explanations, should be displayed conspicuously.

In trying to teach this variable subject one must keep in closest touch with the pharmacist, whose co-operation and help are most valuable, while the head nurses and visiting doctors give us first-hand information relative to results both good and bad. The head nurse also keeps us informed of the trends in popularity and effectiveness; thus we are forewarned regarding impending eclipses due to the forward march of new releases. I cannot overlook the help I have received from students. Although not always recognized, they are truly keen observers of cause and effect. Their youth has a common affinity with "the new" and many of my cherished specimen bottles are due to their vigilance in rescuing them from untimely destruction along with other refuse.

I should like to see more pictures available illustrating therapeutic effects. Since so many of the plant drugs are little used, we miss that concrete bit of vegetation around which to build up our subject. Artists could develop this sort of thing to a more satisfactory degree than has so far been achieved by illustrating the after-effects relative to physiological action. Pictures do so effectively support the written and spoken word.

"Nursing — in the Market Place?"

A very significant article appeared under the title of "Nursing — in the Market Place?" in the January issue of *The American Journal of Nursing*. From it we quote a single paragraph which, judging from certain letters that have recently reached the editorial desk, may also have some application in Canada:

> Nurses live in the midst of the wartime tensions common to all citizens, plus those which are peculiar to hospital and health organizations. We have reason to be extremely proud of the way most nurses are measuring up to the obligations implicit in the word "nurse". We are deeply anxious about those who appear to be more concerned about selling their services to the highest bidder than about making the best use of their professional skill lest they sell their birth right for a mess of pottage.

For a long time each succeeding issue of the *Journal* has published announcements from hospitals all over Canada inviting applications for various staff positions. Many of these, we are proud to say, elicit an excellent response from the fine type of nurse whom they are intended to attract. But among them are others that give rise to certain mis-

givings. A few days ago a nurse, who is the superintendent of a hospital in an industrial town, wrote as follows:

Out of three dozen applications only three gave the essential points of information in the initial reply — that is to say the name of their School of Nursing, year of graduation, and previous experience. Almost without exception they simply asked about hours of duty, days off and salary. Another nurse, in applying for a supervisor's position, stated that since her graduation one year ago she had been employed in a synthetic rubber plant. We agreed that being elastic might be a real qualification. I am afraid that many of us are losing faith in the nursing profession. However, a sense of humour helps!

By way of conclusion we revert to the article quoted above: "This is our war. The effect of what we nurses do now will inevitably influence our status and our usefulness when peace comes. In our home towns people will remember and act upon what we have done at home".

A Tribute to Miss Hersey

In recording with deep sorrow the death of Miss Mabel Hersey, it is fitting that we should hold in grateful remembrance her particular contributions to the Association of Registered Nurses of the Province of Quebec. It is well that we praise famous men and women and Miss Hersey was one of these. To refresh the memory of those who knew something of her deeds of thirty years ago, and to acquaint those who do not, may I remind you that early in 1917 Miss Hersey was one who risked much that others might share her good fortune and profit by her experience.

In the archives of our Association may be seen a complete record of the organization of "The Graduate Nurses Association of Quebec", all of which is recorded in Miss Hersey's own handwriting. In it you will find that the English-speaking nurses of Montreal, under the leadership of Miss Grace Fairley as president and Miss Hersey as secretary, assembled "for the purpose of establishing a standard of nursing preparation and service and to improve the lot of the smaller nursing schools". For three years this little band in Montreal grew and gained strength during which time the groundwork of the framing of the Nurse Registration Act, under which we have developed for twenty-four years, was well and wisely laid. It is easy to realize how greatly Miss Hersey's charm and kindly manner influenced the French-speaking nurses after a time to join forces and so paved the way for the bi-lingual organization that the Association of Registered Nurses of the Province of Quebec eventually was to become.

Our debt to Miss Hersey can in no better way be paid if only in part (for we owe much to her vision and her qualities of heart and mind) than by endeavouring to put aside all selfishness and antagonism and to go forward when our problems appear to be unsurmountable and evil forces are at work to upset all the good that has been accomplished. We must resolve to make our Association worthy of its founders, especially of her who lived among us and bore the heat and burden of the day for so many years.

I have spoken only of her pioneer work, the rest is familiar to you all. The Graduate Nurses Association of Quebec became the Association of Registered Nurses of the Province of Quebec in 1920 through the passing of the Registration Act with which we are all familiar. Let us cherish that memory and hold it in safekeeping always, for in so doing we honour her whose death we now mourn.

E. Frances Upton
Executive Secretary and Registrar.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association.

Inspection of Children's Teeth

MARGOT HEIMBURGER, M. D.

Children's teeth present different characteristics according to the age of the child. When examining a child's mouth, it is therefore important to keep in mind to what age group the child belongs. There are, roughly speaking, three age groups: children under 6 years old; children of 6 to 8 years old; children of 8 to 12 years old.

Children under 6 years old have all their deciduous or baby teeth, ten in each jaw, upper and lower, and occasionally their first permanent molars, the so-called six-year molars. Look for decay in anterior teeth; decay in posterior teeth; decay in six-year molars; gum boils; trench mouth; accidents to anterior teeth. Decay in anterior baby teeth is relatively unimportant since they are replaced comparatively early. The anterior portion of the jaw grows and expands naturally to accommodate the permanent teeth which are usually bigger in size. Most dentists, therefore, do not bother filling anterior baby teeth. Decay in posterior teeth is very important and all small cavities should be filled as soon as possible. These teeth are retained until the age of 10 or 12 years and, if not saved until that age, two serious conditions arise. The child has nothing to chew with for several years and, when these teeth are lost prematurely, the six-year molar is liable to drift forward and close up the space for the permanent bicuspids which erupt out of line and sometimes even become impacted.

The six-year molars are very important teeth because they provide the main chewing surface for the child during the time the deciduous molars are shed and until the permanent bicuspids erupt. The six-year molars are rather liable to decay. Look for it in the pits and fissures of the occlusal or chewing surface, the buccal surface (outside surface nearest the lips and cheeks) and proximal surface (adjoining the second deciduous molar) especially when the latter is badly broken down.

Gum boils occur on the gums next to badly decayed teeth and will be discussed in detail under "toothache". Trench mouth is an infection of the gum caused by germs and it is very contagious. The gums around three or four teeth on one side of the mouth or in front of the mouth are red, swollen, itchy and painful. The child runs a temperature, cannot eat, and is generally quite uncomfortable. The condition should be treated immediately by a dentist or physician. Do not tinker around with trench mouth even though tinkering sometimes

gives quite a bit of relief. Unless the condition is cleared up completely, once and for all, it easily becomes latent or chronic and may flare up again in a week or so when it is much more difficult to get rid of. Impress on the parents that the condition is very contagious. The child should be kept out of school and all utensils the child is using, such as forks, spoons, plates and drinking vessels, should be kept separate from those used by the rest of the family so as not to spread the disease to other people.

It sometimes happens that a child falls or gives its anterior teeth (usually the upper) a severe blow. Such conditions should receive immediate attention. The roots may be fractured or the teeth may be knocked out altogether, breaking some of the jaw bone with them, all of which may permanently injure the permanent front teeth back of them.

Children of 6 to 8 years of age present the following picture: they usually have 4 permanent anterior teeth in place in the lower jaw, 2 or 4 permanent anterior teeth in the upper jaw, the 4 six-year permanent molars in place, and the deciduous eye teeth and the deciduous molars in various stages of dilapidation. Look for small cavities in deciduous molars; decay in six-year molars; gum boils; trench mouth; extractions; malocclusion; supernumerary teeth; accidents to permanent anterior teeth.

Small cavities in deciduous molars at this age should be filled. These teeth are not lost normally until the age of 10 or 12 years and should still render service for a couple of years. Especially does this apply to the second deciduous molars which adjoin the six-year molars. The same considerations apply to decay in six-year molars as in the previous age group, only more so. It sometimes occurs that, for some reason or other, the permanent anterior teeth come through while the deciduous anterior teeth are still in place. In such cases the deciduous teeth should be pulled out immediately. If not, serious disfigurement may result, necessitating costly and lengthy treatment, as the permanent teeth cannot take up their proper position in the jaw. When the permanent bicuspids erupt somewhat ahead of time, it is usually due to the fact that the deciduous molars are very badly broken down. Fragments of deciduous roots should be extracted whenever the permanent bicuspids put in their appearance, as they may deflect the bicuspids from taking up their proper positions.

Malocclusion in the anterior portion of the jaw may be detected by making the child close its teeth. If all the upper anterior teeth overlap the lower, all is well. If one or more of the upper teeth are caught behind or inside the lower front teeth, you have a condition of malocclusion. Refer such a case immediately to a dentist. When caught early, it may be remedied fairly easily. If neglected, it causes grave disfigurement and is difficult and expensive to correct. Supernumerary or freak teeth sometimes appear, although rather infrequently, especially in the upper anterior region. They should be extracted immediately. Accidents to permanent teeth are very serious in this age group and should be attended to promptly.

Children of 8 to 12 years present the following picture: the 4 permanent anterior teeth in the upper and lower jaws are in place; the first permanent bicuspids are in place; the six-year molars are in place. The deciduous eye teeth and second deciduous molars are in process of being shed and replaced. The twelve-year permanent molars are erupting behind the six-year molars. Look for decay in permanent teeth, six-year molars, upper anterior teeth, permanent bicuspids; deciduous teeth needing ex-

traction; trench mouth; dirty teeth; malocclusions; accidents.

Go over the six-year molars carefully. The upper anterior teeth sometimes decay in this age group. Look for decay on the proximal surfaces, and also on the lingual surface, inside nearest the palate since decay is sometimes found in the little pits of that surface. The lower anterior teeth very seldom decay, but should be checked in poor mouths. Decay in permanent bicuspids is serious and should be attended to without delay as it usually progresses very rapidly. Look for stumps of deciduous teeth which need extraction as for the previous age group. Trench mouth occurs rather rarely in this group. Dirty teeth should be lectured about with considerable emphasis. Sometimes a child gets into the bad habit of not brushing his teeth vigorously because the mouth has been sore for several years with broken-down deciduous teeth. Now is the time to check up and remind him that his new teeth have to last him a lifetime and deserve to be treated decently. Malocclusion and accidents require the same attention as in the previous groups.

Toothache: there are five kinds of toothache — when decay has reached the nerve, but the nerve is still alive; when decay has reached the nerve and the nerve is dead; erupting teeth; sore gums and canker sores; sinus infections. When decay has reached the nerve, but the nerve is still alive, the child complains of toothache while eating, rarely at night; the tooth is firm and not sore to pressure. Oil of cloves works in these cases quite satisfactorily. Apply it on a pledget of cotton directly in the cavity; the application may have to be repeated several times, until the nerve finally dies. Be careful not to get the oil of cloves on the tongue, as it burns and has a strong taste.

When decay has reached the nerve and the nerve is dead, the child complains of toothache, mostly at night. The tooth is loose and sore to pressure. Sometimes there is considerable swelling of the gums, at times swelling of the face as well. Oil of cloves and other medicines are useless. If the gums alone are swollen, there is a gum boil. This condition should be treated as soon as possible by a dentist. If the face is badly swollen, the condition is quite serious and if neglected may lead to blood poisoning. Some relief may be obtained by applying heat.

Sometimes the twelve-year molar causes some discomfort when coming through, but rather seldom. When the gums are sore and uncomfortable near three or more adjoining teeth, suspect trench mouth. Canker sores are ulcerating lesions found on the inside of the lips and cheeks, on the gums or on the tongue. These are sometimes caused by rubbing against sharp edges of broken-down teeth; more often they appear as a result of a general acid condition due to indigestion. These sores are quite painful, especially when eating, and may persist for as long as a week or ten days. A dose of salts usually clears up the condition. After a severe cold the child may have a sinus infection and sinus pain is sometimes blamed on the upper molars or bicuspids. When you have checked everything else and there is still a toothache in the upper molar and biscupid region, suspect sinus infection. It occurs rather rarely.

Editor's Note: The convener of publications wishes to explain that it has been necessary to interrupt the continuity of the series of articles on staff education which were to have appeared in consecutive issues of the *Journal*. The series will be resumed as soon as possible.

Plea for Assistance in Sanatoria

There has existed for more than a year an acute shortage of nursing staff in several of the Ontario sanatoria; especially is this so in the Weston and Gravenhurst Institutions where sixty and seventy-five beds respectively are closed as a result. There are patients on the waiting lists of all sanatoria and, in those in which there are surgical units, major thoracic surgery is many months behind. This is a most serious situation in that the turn-over of patients is slowed down; patients might not now be occupying beds urgently needed for active cases if they had been given the advantage of surgical procedures. Many infectious cases of tuberculosis are remaining in their homes because of lack of available sanatorium beds. Few of these patients have had the necessary training in the precautions required to prevent infecting others. They are a definite danger to those in contact, especially children and young adults in the household, who will, as a result be the potential cases of the future.

In 1941 there was a total of 424 graduate nurses in the thirteen sanatoria, and now only 354, a decrease of 16.5%. In Gravenhurst Sanatorium the decrease has been approximately 50%. The Weston and Gravenhurst sanatoria are appealing to all nurses not now employed to offer their services. For those living in, the salary to start will be $80 plus $30 perquisites (room, three meals and laundry), with $5 increase in six months and a bonus of $50 at end of each year's continuous duty. For those living out, the salary will be $100 plus one meal and laundry with a reasonable allowance for transportation from the home of the nurse. There is attractive accommodation for nurses within the nurses' residence at each sanatorium. Every graduate nurse being employed will be considered, if satisfactory, on the permanent staff.

There appears to be a fear in the minds of some nurses of contracting tuberculosis if exposed to tuberculosis patients in a sanatorium. The patients are trained to cover their mouths when coughing, and the proper procedure in the disposal of their sputum. No nurse is permitted to begin duty on the wards before being given instruction as to precautions necessary to her own protection.

G. C. Brink, M. B.
Director, Division of
Tuberculosis Prevention,
Ontario Department of Health.

The R.N.A.O. Annual Meeting

The annual meeting of the Registered Nurses Association of Ontario will be held at Hotel London, London, Ontario, on April 12, 13, and 14, 1944. The meeting will open on Wednesday, April 12 at 2 p.m. During the afternoon important reports will be presented. According to present arrangements, Wednesday evening will be free for delegates to plan social activities for alumnae groups. On Thursday morning the Sections will hold their business meetings, followed by a general session in the form of a panel discussion — "Nursing Service in Family Life". Those participating will include representatives from hospitals and schools of nursing, general nursing, public health, industrial nursing and the Nurses Council on Tuberculosis. Health insurance and nursing service, a question of great interest to all nurses, will be a special feature on Thursday afternoon. The annual banquet will be on Thursday evening when an address on "The Future Population of Canada" will be given by Dr. E. G. Pleva, Ph.D., University of Western Ontario. Friday, the third day, will include reports of interest and all unfinished business.

This is an advance notice and it is hoped that as many members as possible will plan to be in London from April 12 to 14. It may be necessary to make some slight changes in the arrangement of this outline of the programme but members will receive a copy before the end of March.

Matilda E. Fitzgerald
Secretary-Treasurer

Notes from the National Office

Contributed by KATHLEEN W. ELLIS

General Secretary and National Adviser, The Canadian Nurses Association.

The Biennial Meeting — 1944

The date of the twenty-second General Meeting of the Canadian Nurses Association may still seem a distant one, but June 26 will soon be here. Long before it arrives conveners of committees, and others who share the responsibilities of preparing the programme, are busy planning to ensure a successful convention.

Miss Marion Lindeburgh, Chairman of the Programme Committee, has approved the release of the following information: This year the programme is being adjusted to meet wartime conditions. More formal reports will appear under such captions as "Joining Forces", "Professional Relationships", "Strengthening our National Organization" and "Postwar Planning". It is hoped that special messages from our Nursing Sisters overseas will be included.

The whole programme is designed to provide opportunity for adequate discussions of common problems that will be brought to the meeting, when delegates from all parts of Canada gather in Winnipeg. To give an enriched background, the support of a limited number of outstanding speakers has been secured. Canadian nurses will all be very pleased to know that Miss Anna Schwarzenberg, Executive Secretary of the International Council of Nurses, has consented to be one of these. Miss Schwarzenberg is already known personally to many Canadian nurses, especially those who recall her "in action" at the International Congress in 1937. A further announcement regarding other speakers will appear in the next issue of the *Journal*. While these speakers will be limited in number, they have been chosen because of their knowledge and ability to deal with the special subjects of direct interest to every nurse in Canada.

The Special Levy

During the past year an appeal was made to provincial associations for an additional donation of 25c per member to provide for the attendance at meetings of the Executive Committee, C.N.A., of the following: the five officers of the Canadian Nurses Association, namely: the president, first and second vice-presidents, honourary secretary and treasurer; the conveners of the three Sections, the chairman of the Committee on Nursing Education, and the Executive Secretary. This levy provided also for the attendance at one General Meeting of the Executive Committee of a voting delegate from each provincial association. This representation was in addition to that provided for at the biennial meeting in 1940, when it was decided that a councillor from each of the two neighbouring provinces to the one in which the President of the C.N.A. is resident, should be invited to attend interim executive meetings of the Canadian Nurses Association.

Through the support of the special levy much wider representation at executive meetings has been made possible

during the past year. At the General Meeting in June 1944, delegates are to vote on a proposed increase in annual affiliation fee from 75c per capita to $1.00. It is understood that the additional assessment is recommended to enable the policy regarding attendance at executive meetings, tried out during the past year, to become an established practice.

A National Conference on Health Insurance

A conference of National Health Organizations on Health Insurance was held in Toronto on January 28 and 29, 1944. This meeting was called by the Canadian Medical Association to discuss problems which are of mutual interest and to secure a better understanding of particular ones affecting any one or more of the groups. The further purpose of the conference was to permit free exchange of ideas on those topics which concern all groups, such as: the provision and maintenance of professional education, the planning of health work in rural and urban communities and other common objectives, inseparable from sound organization to provide health service for the people of Canada.

Fourteen national health organizations were represented at the conference, including the following: Canadian Medical Association, Canadian Public Health Association, Canadian Nurses Association, Association of Canadian Medical Colleges, Canadian Tuberculosis Association, Canadian Hospital Council, L'Association des Médecins de Langue Française de L'Amérique du Nord, Canadian Dental Association, Royal College of Physicians and Surgeons of Canada, Canadian National Committee for Mental Hygiene, Health League of Canada, Medical Council of Canada, Canadian Pharmaceutical Association, National Research Council. Dr. A. E. Archer, chairman of the General Council of the Canadian Medical Association, presided.

Delegates from the Canadian Nurses Association were: Miss M. Lindeburgh, president; Miss Edna Moore, representing public health nursing; Miss F. Munroe, hospitals and schools of nursing; Miss M. Baker, general nursing. Rev. Sr. Allaire represented both the Canadian Nurses Association and the Canadian Hospital Council. The National Adviser, C.N.A., also attended the meeting as a delegate.

The programme at the conference provided for a brief summary to be given by a representative of each organization on: "Matters of Chief Concern in Health Insurance". Further discussion centred round the question: "What features should be included in any plan of health insurance to insure the best form of health care in (a) rural areas? (b) urban area?" and the subjects of "Professional Training—undergraduate and post-graduate" and "Enlightenment of the Public". Short introductory papers were given on each of these topics, three by representatives of the Canadian Nurses Association. These will be included in a more detailed report of the conference which will appear in a subsequent issue of the *Journal*.

Discussions were lively and to the point, although conclusions reached were of a general nature. It seemed to be the unanimous opinion of those present that further joint conferences would be helpful, in order that there may be a general understanding of: (a) the part that each organization will take in a co-ordinated health plan; (b) the way in which this can be most effectively accomplished; (c) desirable steps that should be taken for the enlightenment of the public. Throughout the meetings the fact was stressed that according to the Proposed Enabling Bill further legislation would have to be worked out in each province governing the administration of a health insurance plan.

Organizations attending the conference were urged to crystallize their ideas into resolutions. It was stated that these were to be formulated for information only. They were accepted, but not endorsed at the meeting. For the most part resolutions formulated by the delegates of the Canadian Nurses Association covered conclusions already agreed upon at executive meetings. However, they will be sent to provincial associations and presented at C.N.A. executive meetings for further consideration before being published.

Nurses Repatriated from the Orient

In the last issue of the *Journal* a very special welcome was extended to nurses returning home from the Orient. It was also announced that soon after their arrival, the nurses, whose names were reported through Treasury Office in Ottawa, received a letter of welcome from Miss Grace Fairley, chairman of the British Nurses Relief Fund Committee. In this letter, Miss Fairley expressed most feelingly the great desire of the Canadian Nurses Association to give assistance to any of the nurses returning from the Orient, if this would be acceptable. To date few of the nurses have indicated that they wish to avail themselves of this assistance, but they have expressed deep appreciation of the offer received from their national organization and have promised to remember that the Canadian Nurses Association is "standing by" ready to assist should it be privileged to do so.

One letter of appreciation brought with it a contribution to the fund "of which I now hear for the first time". This gracious donor further expressed regret at having been "cut off" from this and similar opportunities to participate in professional activities. It is significant to reflect on these sentiments of professional loyalty, and on the opportunities referred to by the writer as ones that have been available to all nurses in Canada, who have been spared the harrowing experiences and additional burdens they now ask to share with their sister nurses from overseas.

Additions to the Horder Report

Two additional sections of the Report of the Horder Committee on Nursing Reconstruction have recently been published in Britain and deal with the recruitment and education of students who intend to become State Registered Nurses. It will be remembered that the first section was exclusively devoted to a study of the Assistant Nurse because the Committee considered it futile to set up professional standards until her status and functions had been determined. The latest additions are described by the *Nursing Times* as revolutionary in character in that they stress "student status for the student nurse" and insist that "the nation should make a financial contribution to the education of its nurses". It is plainly stated that unless financial support is assured to schools of nursing "the student status of the student nurse will remain more of a myth than a reality". The Government has already made grants to assist the establishment of the Rushcliffe salary scales and there is every reason to hope

that the Horder Committee will meet with an equally favourable response. If this basic principle were to be accepted in Britain it might be easier to persuade our Canadian Government to do likewise. More power to our British sisters in their gallant fight.

The principal recommendations are summarized as follows:

Student Status: While the student nurse must be regarded as a component part of the hospital personnel in order that she cultivate a sense of responsibility, her status as a student nurse should be fully recognized by the trained nursing staff, the medical staff and the governing body of the hospital, and her work should be regulated accordingly.

A Nation-wide Plan: While a marked reduction in the number of training schools is desirable, if a high educational standard is to be maintained, it is essential that there should be no unnecessary obstacle to the flow of suitable new entrants to the profession. These conditions are linked with the important question of an improved ratio of nurses to patients.

Nursing is not merely an item in the nation's medical service but a profession parallel to that of medicine, occupying an appointed and an increasingly important place in the national plan for health.

The Educational Approach: Though the nurse's training is still to a certain extent an apprenticeship, there must be a much larger proportion than at present of permanent trained staff to supervise and explain her work, and sufficient ancillary staff to perform certain normal routine duties.

Grants from National Funds: The State should implement recommendations that grants be given from national funds to all recognized training hospitals in respect of the national work done in the training of nurses.

Payment of Fees: The Committee supports the principle of payment by the student nurse for her training when this is possible, but emphasizes that no good potential nurse should be debarred from training for lack of means. The expenses of such candidates as lack means should be met by liberal maintenance grants and scholarships from national and other funds.

Entrance Qualifications: The chief entrance qualification should be the School Certificate (or equivalent), or qualification in Part 1 of the Preliminary State Examination.

All candidates who do not possess either or both of the foregoing qualifications should pass the General Nursing Council's Test Educational Examination.

Intelligence Tests: The Committee considers that intelligence tests have a supplemental value in enabling hospitals to assess the ability of the candidates.

Four-years Course: The Committee recommends the establishment of a wider basic training for general nursing, covering four years, to include short, varying periods of experience in obstetric nursing and in branches which may not hitherto have been covered such as fever, tuberculosis and mental nursing, and an elective six months in a speciality in the last year.

Nurse Training Units: Nurse training units should be either: large parent hospitals with opportunities for training in certain specialities in one or more subsidiary hospitals; or groups of smaller hospitals which would combine to provide the complete basic training. Each unit should have its own nurse education committee, composed of the matrons, nurse teachers and representatives of the medical staff, with power to co-operate local representatives of the teaching profession and other suitable persons. The matron is head of the nurse training school, and as such, should have direct access to the executive committee on all nursing matters.

The Block System: The Committee recommends the adoption of the principle of the block system of training for nurses throughout the country. Under this system the student is relieved for varying periods from attendance on the sick, the greater proportion of the theoretical training being given when she is free to study.

Finance: Educational grants should be made from national funds to meet most of the additional cost entailed by the adoption of the block system.

STUDENT NURSES PAGE

The Continuous Water Bath

LENORE JAMES

Student Nurse

School of Nursing, Ontario Hospital, Kingston

Although water is, without a doubt, the most ancient of all remedies, it was with fear and trembling that Sydenham (1624-1689) published his treatise on hydriatic therapy as opposed to bleeding to reduce temperature in fever. Thanks to the advance in medical science, water now holds an honoured place as one of the most valuable therapeutic agents in the treatment of disease. This may be due to the fact that water is usually easily obtainable in large quantities, and lends itself readily to varying forms and temperatures. When we remember that the human body is 63-67% water we realize the important part it plays in our physical well-being.

Hydrotherapy covers a wide field and is defined as "the remedial use of water, in any of its forms, ice, liquid or vapor, internally or externally". The technique of hydrotherapy is one of the specialties of nursing, but every nurse should have a working knowledge of its general forms and principles. Even as junior nurses we have watched the miraculous effects of the terse order "push fluids — sponge frequently". However, there may be some of us who have not observed a patient in a continuous water bath, and for them the following description may be of interest.

What is a continuous water bath? It is one that is administered for hours, days, weeks or months. The prescribed temperature must be maintained by keeping a stream of water flowing through the tub. The usual duration is from two to four hours at a time. In extremely agitated patients the treatments are continued over a period of weeks. In toxic conditions the baths are used until all signs of toxicity have disappeared. Circumstances often decide the time of administration. In our hospital, suicidal or assaultive patients are treated at the time that permits the greatest number of staff. Similarly, short periods in the evening prove more beneficial for sleeplessness.

The bath is used most frequently for sedative effect, although it can be used for the opposite — to stimulate circulation. It has also an eliminative function in toxic conditions and is usually employed in conjunction with other nursing measures such as extra fluids by mouth, lavage and proctoclysis. Used in this way it aids the skin in excreting the waste products of metabolism, or other poisons whose accumulation within the system have resulted in toxicity. It is better than drugs as a hypnotic and has been used to relieve pain, as in burn cases. It is also beneficial in the treatment of decubitus ulcers.

The water used in continuous water bath should be so employed as to be unirritating, without percussion and of such a temperature as to shield the body from the continued excitation resulting from the contact of skin with clothing, changing temperatures and various other disturbing factors. As a result, the nerve centres, being almost completely at rest, are given a chance to gather a store of energy. Thus the so-called neutral bath is not really neutral in its physiological effects but is recuperative and energizing.

Equipment: The room is set apart for continuous baths only. The walls and ceiling are finished in a subdued shade, often green. The light is softened with shaded windows. Room temperature during treatment is kept between 74-80 degrees Fahrenheit and the patients are at all times protected from drafts. The tub has an outlet for the overflow near the top (so that the patient will remain covered with water) and there are several inlets near the bottom of the tub which are directed downwards to avoid percussion. A cradle and cover is made of canvas, adjusted to fit the tub and strapped securely in place. This protects the patient's body from the tub and can be so adjusted that the knees are flexed for greater relaxation. Care must be taken in putting on the cover, so that it does not rest heavily on any part of the patient's body. The necessary linen includes a soft sheet to line the cradle and protect the patient; a cotton gown; a pillow case for the rubber air-pillow at patient's head; a large bath towel for the rub-down at the conclusion of the treatment; and a bath mat. A tray containing olive oil and fluffs, a paper bag for waste, a bowl of ice chips and compresses, a pitcher of nourishing fluid and drinking glasses should all be available. A bath thermometer is kept in the tub throughout treatment.

Procedure: Before the treatment the patient is asked to void. The palms of her hands and soles of her feet are well anointed with olive oil to prevent "water-logging". The tub should be about two-thirds full and the temperature of the water should be kept between 92 and 98 degrees Fahrenheit, according to the doctor's order or the patient's comfort. Many of our patients require considerable reassurance before they will step into the tub. Some have the belief that we will "duck" them into icy or too hot water. Others, owing to their psychotic condition, have somatic delusions — their blood will be washed down the drain, and so on. Many are apprehensive, agitated or hyperactive, and they tax the ingenuity as well as the patience of the nurse, the first time they are placed in the tub. But they improve as the treatments are continued and the harder they are to manage at first, the greater the satisfaction when their condition is relieved.

Nursing care during treatment includes the following measures:

1. We never leave the room except when relieved by another nurse, and we keep the door closed to prevent drafts and exclude stimuli.
2. We try to cultivate a quiet, unobtrusive manner so that the patient will relax without realizing she is under close observation. If she is apprehensive we try to reassure her, and insofar as it is feasible, we explain the treatment.
3. The patient's temperature has been taken, and must be close to normal if she is to have treatment, but we chart her pulse and the temperature of the water every fifteen minutes while she is in the tub. The automatic gauge on the thermostat indicates the approximate temperature, but we use the bath thermometer as an added precaution.
4. The patient's hair is protected by bringing it up on the head or it may be wrapped in a towel or cap.
5. Cold compresses are applied to the forehead continuously to prevent headache. With the shortage of gauze we

find that face cloths make a suitable substitute. If the patient falls asleep, as is often the case, it is better to omit the compresses rather than awaken her.

6. Nourishment is given at intervals. If our patient is emaciated, or dehydrated, we utilize this time to give extra food, mainly in fluid form. They will often eat or drink in the bath when they will not at other times. Regular meals may be served during a treatment.

7. Close observation of the patient is required for every moment she is in the tub. We watch her colour, pulse and respirations, as these indicate whether or not she is becoming exhausted. In suicidal patients, we have to be sure their heads are always above water and that they cannot reach the draw-cords to strangle themselves.

8. At the conclusion of the treatment (time prescribed by the doctor) the patient is given a rub-down. The towel may be warmed on the radiator or kept in the warming cabinet. If the bath were used for hypnotic or sedative effect, omit the rub, but dry thoroughly. A dry gown is then put on, the patient is allowed to void, and is returned to bed. A half-hour later, an alcohol rub and massage may be administered to aid the therapy to relieve insomnia.

Dangers and precautions: The greatest danger during treatment is exhaustion, but the observant nurse will not allow this to occur. After treatment, the danger is chilling. It is best to keep the patient in bed at least an hour or two. Of course, the danger of burning must not be overlooked, but if a bath thermometer is used, the nurse cannot help but feel the water every time she reads it. Close observation will prevent the danger of suicide. If rash should occur, due to irritation of chlorine in the water, calamine lotion is applied, and the treatment may be discontinued until the condition is relieved. The continuous bath is contraindicated if the patient has an elevation in temperature, if catamenia is present or if she has a rash of infection. It should be employed with care in debilitated patients, and never to the point of exhaustion.

This treatment, though simple, should only be administered by one who knows the desired results, and who fully understands the therapeutic principles involved. Like any other nursing measure, in inexperienced hands it can do more harm than good.

REFERENCES

Kellogg: Rational Hydrotherapy.

Wright: Hydrotherapy in Hospitals for Mental Diseases.

Approved Films on Food and Nutrition

The committee on evaluation of motion pictures, associated with New York City Food and Nutrition Program, has just published a selective catalogue of films that deal in a popular way with the vital question of nutrition. Some of them are sponsored by commercial firms that have branches in Canada, such as Swift and Company, Westinghouse Electric and the H. J. Heinz Company. The Metropolitan Life Association distributes a film with the beguiling title of "Proof of the Pudding" which shows, in a skilful and appealing way, the relation between good nutrition and abundant health. Scenes in a zoo are used to emphasize the well balanced diets of animals and the carelessness with which human beings select their food.

The National Film Board of Canada distributes several excellent films, including one called "The Training Table" produced primarily to impress upon the members of the Royal Canadian Air Force the importance of a sound diet. The discussion of basic nu-

trition facts is clear, orderly and detailed, while the constant relating of these facts to the activities of pilots and ground crews add a special timely interest to the subject. Few films have explained the roles of the various nutrients (especially the vitamins) with greater facility or have portrayed more convincingly the importance of a sound diet to maximum physical efficiency. The excellent colour photography and dramatic aviation shots also merit special praise.

The National Film Board is also responsible for a film entitled "Food — weapon of conquest" which shows how Germany is using food as a political weapon by rewarding the occupied countries which collaborate and punishing others by slow starvation. This sequence is based on captured enemy films. Other sequences illustrate the food requirements of our own soldiers and industrial workers.

Information concerning arrangements for renting these films can be obtained from The New York City Food and Nutrition Program, 45 Lafayette St., New York 13, N. Y. The catalogue costs 25 cents.

Book Reviews

French Canada in Transition, by Everett C. Hughes, Associate Professor of Sociology, University of Chicago. 224 pages. Illustrated. Published in Canada by W. J. Gage and Company, Toronto. Price $3.00.

The specific purpose of this book is to present the problems, human, social, economic and civic, which arise when a rural community is transformed into a fast-growing industrial town. In such a town the traditional institutions are inevitably exposed to alien influences and the diplomatic relationships between French and English are disturbed. Part One is devoted to a masterly description of the rural community as exemplified in the Province of Quebec where the parish is the key institution and exercises almost as profound an influence as the close-knit habitant family itself. The active integration of religious and secular life is clearly demonstrated and the power of the parish priest as guide, philosopher and friend is vividly portrayed. Part Two tells the story of what happens when industry enters the picture. The effect of alien ownership and direction upon the French Canadian workers is analyzed with complete detachment but it is quite evident that Professor Hughes is keenly aware of the mutual antagonism which separates the groups from one another and which makes it so difficult for them to live and work together in harmony. Although the book is a scientific treatise and is fully documented throughout, human values are by no means neglected. The religious ceremonies, social contacts, fashions, popular literature and amusements are all described with a sympathetic insight and kindly humour that makes them come alive. Everyone who wants to promote friendly relationships between the two racial stocks which together constitute the bulk of our Canadian population should read this book. In writing it, Professor Hughes has made a real contribution to national unity.

Principles and Practice of Rehabilitation, by John E. Davis, Sc.D. 208 pages. Published by A. S. Barnes and Company, 67 West 44th St., New York, 18. Price $3.00.

This book appears at a critical juncture when there is a real need for it. Rehabilitation cannot wait until the war is over but must be undertaken here and now. Dr. Davis is associated with the Veterans Administration Facility and has had long experience in this particular field. His stated purpose is "to present a usable psychology of practical rehabilitation" and he has certainly succeeded in achieving it. The first chapter deals with the relative effect of war and of economic depression upon employment and is illustrated with some illuminating charts. Succeeding chapters discuss the psychiatric and the psychological approach in a variety of situations and offer some useful information concerning the more com-

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mon deviations from the normal. Considerable attention is given to interest and effort theories, based on a series of case histories. A chapter on elemental principles of mental, nervous and physical reconstruction leads naturally to a study of modern methods and therapeutic objectives. There is a place for this book in all nursing libraries.

The Man Born to be King, by Dorothy L. Sayers. Published by Victor Gollancz, London.

This book contains twelve plays which were produced for the Religious Department of the British Broadcasting Corporation by Val Gielgud. The Plays tell the story of the life of Our Lord from the Nativity to the Ascension. Dorothy Savers has written in present-day language and with such simplicity that a captured interest is sustained. Her sincerity conveys the vividness and reality of the vital human relationships related to daily experience. She has made a thorough investigation of biblical and theological sources. Familiar passages, such as the Beatitudes and the parables, are woven into a modern setting and Christianity is made a living faith. Nurses in all branches of the profession would enjoy this book, especially if it were read by groups, thus promoting fellowship and affording a medium of expression.

— VERA B. ALLEN

The Hospital in Modern Society, edited by Arthur C. Bachmeyer, M.D., and Gerhard Hartman, Ph.D. 766 pages. Published by The Commonwealth Fund, 41 East 57th St., New York, 22. Price $5.00.

Here in one compact volume is the essence of the available published material on hospital administration. This book is encyclopaedic in its range and includes 145 articles written by 98 authors. The subject matter has been taken from periodical literature and from committee reports and covers a great variety of topics closely related to the central subject. Nursing education and nursing service have a section all to themselves which contains twelve articles, all of them excellent. Nurse administrators will find the chapters devoted to the functions of boards of management and to medical staff organization extremely enlightening as well as thoroughly practical. Plant maintenance, purchasing, food service and personnel relationships all receive due consideration. A good insight is also given into group hospitalization and health insurance schemes.

Nurses Handbook of Obstetrics, by Louise Zabriskie, R. N. and Nicholas Eastman, M.D. Seventh edition. 674 pages. Illustrated. Published by the J. B. Lippincott Company; Canadian Office: Medical Arts Building, Montreal. Price $3.25.

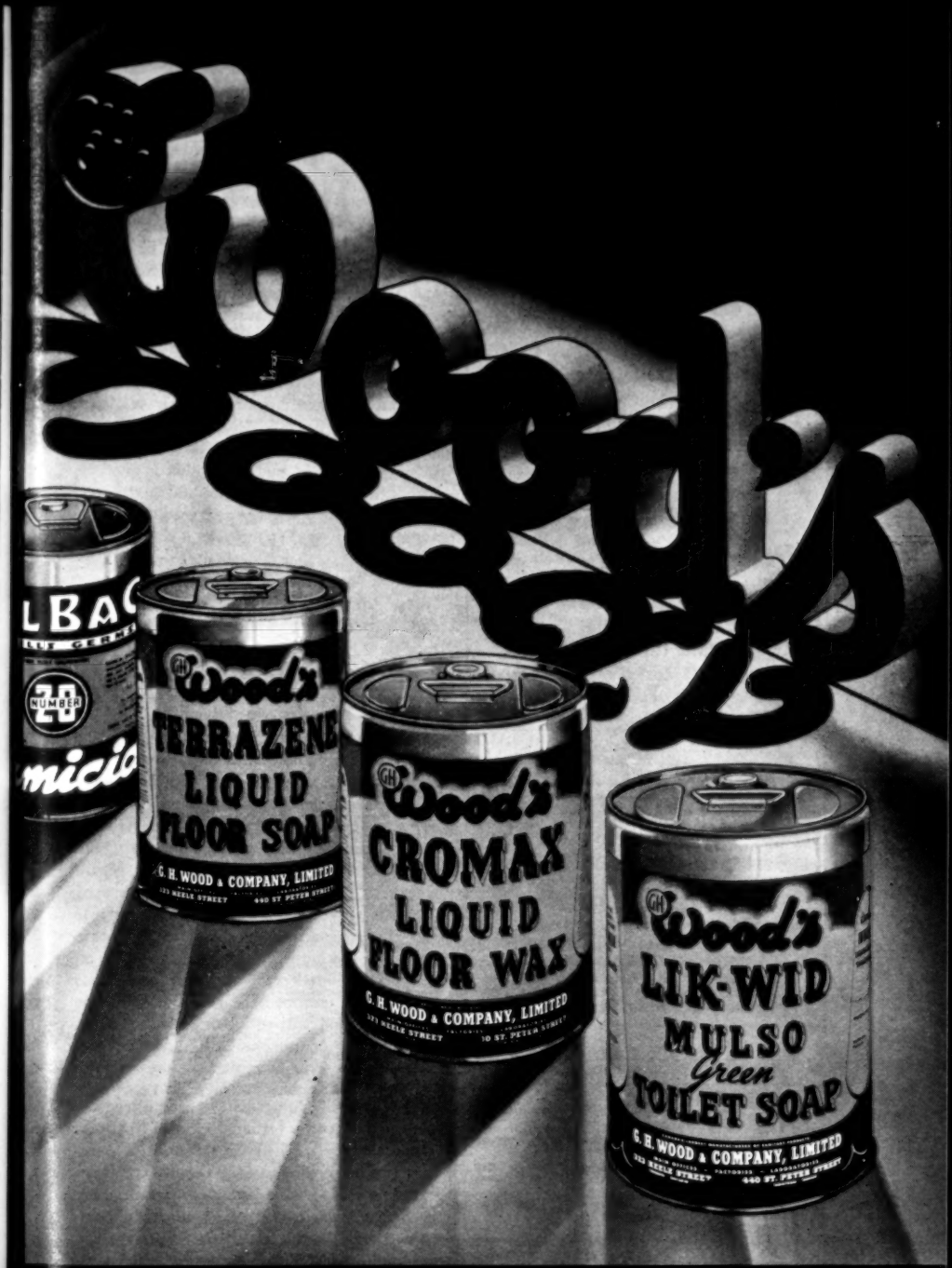
Having attained its seventh edition, this book may justly claim to be a nursing classic. The book has been almost entirely re-written and many excellent illustrations have been added to the text. The subject matter is arranged in six units each of which is followed by an appropriate review and questions. Special emphasis is placed on the public health aspects of obstetrics and there is a good chapter on teaching methods.

Urology for Nurses, by Oswald Lowsley, M.D., F.A.C.S. and Thomas Kirwin, M.D., F.A.C.S., in collaboration with the Nursing Staff of the Department of Urology, The New York Hospital. 454 pages. Illustrated. Published by the J. B. Lippincott Company; Canadian Office: Medical Arts Building, Montreal. Price $3.50.

The authors of this book emphasize the fact that urological nursing demands tact and patience as well as a high degree of technical skill. The reason that some nurses dislike this branch of nursing may be traced to the fact that they have neither the knowledge nor the experience to cope with the special difficulties it involves. A careful reading of this book will be found most helpful by graduate nurses.

Pharmacology, Materia Medica and Therapeutics, by Charles Solomon, M. D. in collaboration with Hazel Houston, R. N. Fifth edition. 755 pages. Illustrated. Published by the J. B. Lippincott Company; Canadian Office: Medical Arts Building, Montreal. Price $3.25.

This standard textbook has undergone thorough revision and much new material has been added to it. Particular attention has been given to the sulfonamides, especially to the prevention and treatment of toxic effects.



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REGISTERED NURSES ASSOCIATION OF NOVA SCOTIA

The Registered Nurses Association of Nova Scotia wishes to announce that a change in their office address from 413 Dennis Building to **301 Barrington Street, Halifax,** took place on March 1, 1944.

Placement Bureau

A Nurses Placement Bureau was opened at this office on the same date under the direction of the present Registrar, Miss Jean C. Dunning, R.N. Information regarding Positions for Nurses may be obtained from this office.

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Mental Hygiene

Since the war began there has been a progressive increase in the number of young children referred for treatment because they manifest signs of nervousness, fears, shyness, seclusiveness, sleep disturbances and temper outbursts as a result of marked feelings of insecurity. These symptoms appear to be an expression of anxiety on the part of children who are insecure in their relationship to their parents. Because in many instances the father is away from home with the Armed Forces, and the mother is at work in one of the war industries, these children are given inadequate care and readily develop a state of anxiety. If they are not given proper treatment they develop abnormal patterns of behaviour and subsequently may become hypersensitive, neurotic, depressed and mentally ill. They therefore require special psychiatric treatment, guidance and opportunities to develop a more complete sense of emotional security.

During the past year there has been a further increase in the number of older children and adolescents who were referred for treatment because of aggressive anti-social tendencies which manifest themselves in the form of disobedience, rebelliousness, stealing, truancy from home and school and other types of delinquent conduct. There is a very real need for the development of adequate psychiatric facilities as part of the Juvenile Court organization, because only by making a proper analysis of an adolescent's intellectual and emotional needs can suitable treatment be given to overcome aggressive and anti-social behaviour. Mental disease is a very serious health problem and a marked economic burden on the community. And this burden may become even greater in the immediate post-war years. One of the truly formidable tasks that lies ahead is that of helping to guide and redirect into socially useful channels the aggressive and hostile impulses which have been mobilized in everyone against the common enemy. If this task is not satisfactorily accomplished then we may again be confronted as we were in the years following the last war with a generation of disillusioned, unhappy young people who will tend to be anti-social in thei ttitude to life and

WANTED

Applications are invited for the position of **Travelling Instructor.** Preference will be given to **Registered Nurses** with special preparation for, and experience in, teaching and administration in hospitals with schools of nursing. Applications should include statement of age, training and experience, and be sent to:

The Registrar, Saskatchewan Registered Nurses Association, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon, Sask.

WANTED

Vancouver General Hospital desires applications from registered nurses for **General Duty.** Please state in first letter date of graduation, experience, references, etc., and when services would be available. Eight-hour day and six-day week. Other details and salary information will be given. Apply to:

Miss E. M. Palliser, Principal & Director of Nurses, Vancouver General Hospital, Vancouver, B.C.

WANTED

A Night Supervisor is required for 120-bed hospital. Position vacant on February 1, 1944. The salary is $100, plus full maintenance. Apply to:

The Superintendent of Nurses, Galt Hospital, Lethbridge, Alta.

WANTED

Applications are invited **immediately** for the position of **Night Supervisor,** with special training in Obstetrics, for a 70-bed hospital. The salary is $100 per month, plus full maintenance. Apply to the:

Superintendent, Salvation Army Grace Hospital, 1156 Wellington St., Ottawa, Ont.

WANTED

Applications are invited from registered nurses for **General Duty** in a **Tuberculosis Sanatorium** of 190 beds. When writing please state previous experience, age, etc. The salary offered is $85 per month, with full maintenance. Address applications to:

Superintendent of Nurses, Fort William Sanatorium, Fort William, Ont.

WANTED

Ward and Clinical Supervisors are required for a 311-bed hospital. The salary is $90, plus maintenance. Apply, stating **age,** qualifications, experience time available, etc., to:

Director of Nursing, City Hospital, Saskatoon, Sask.

WANTED

Nurses are required for the newly estabilised Huntingdon County Hospital. The salary is $80 per month, with full maintenance. Apply to:

The Huntingdon County Hospital, Huntingdon, Box 260, P.Q.

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Courses for Graduate Nurses

(1) A three-months course is offered in Obstetrical Nursing. (2) A two-months course is offered in Gynecological Nursing. For further information apply to Miss Caroline Barrett, R.N., Supervisor, Women's Pavilion, Royal Victoria Hospital.

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(3) A course in operating room technique and management is offered to nurses with graduate experience in operating room work. (4) Courses are also offered in medical nursing; surgical nursing; nursing in diseases of the eye, ear, nose and throat; nursing in urology. For further information apply to Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital.

ROYAL EDWARD LAURENTIAN HOSPITAL

Ste. Agathe Division

Added Experience for Graduate Nurses in the Control and Nursing of Tuberculosis

For a limited period only, and in order to meet the urgent demand for nursing service, experience in nursing tuberculosis is offered to graduate nurses. Organized theoretical instruction, combined with supervised clinical experience, will be available. A salary of $75 per month will be paid and full maintenance will be provided. Further information may be obtained from:

Miss M. L. Buchanan
Superintendent of Nurses
Royal Edward Laurentian Hospital
Ste. Agathe des Monts, P.Q.

who in the face of unusual stress will more readily develop nervous and mental disorders.

Editor's Note: These excerpts are quoted from the annual report of Dr. Baruch Silverman, Director of the Mental Hygiene Institute, Montreal.

M.A.R.N Travelling Instructor

The Manitoba Association of Registered Nurses is pleased to announce that Miss Mabel Faust has commenced her duties as provincial travelling instructor. She is a graduate of the School of Nursing of St. Boniface Hospital and has taken the course in public health nursing offered by the McGill School for Graduate Nurses. After serving successively as instructor of nurses at the Grey Nuns' Hospital in Regina and as a member of the staff of the Victorian Order of Nurses in Montreal, Miss Faust was appointed superintendent of nurses of the United Church Mission Hospital in Central Africa where she spent five years. After attending the International Congress of Nurses in London in 1937 she returned to Canada and became superintendent of nurses at the General Hospital in Prince Rupert, British Columbia. In 1941 Miss Faust travelled under the auspices of the Phelps Stokes Foundation for the purpose of studying hospital administration and nursing education in the United States.

In her capacity as travelling instructor, Miss Faust will organize and direct post-graduate clinical courses, and will assist in the organizing of in-service programmes of staff education in schools of nursing in Manitoba. She will thus have an opportunity of assisting supervisors and head nurses to estimate the teaching facilities available in various units in the hospitals. In addition, she will co-operate in building up staff education programmes in hospitals which do not conduct schools of nursing. Hospitals throughout the Province have been informed that the services of the travelling instructor are now available and have been invited to send in suggestions as to other means by which she might be of service to them.

R.N.A.P.Q. Annual Meeting

The annual meeting of the Registered Nurses Association of the Province of Quebec will be held in the Windsor Hotel, Montreal, from May 15 to 17 inclusive and a most interesting and stimulating programme is assured for each language group. A dinner meeting will be held at which outstanding speakers will deliver addresses on world affairs and sufficient sessions are being planned to ensure full discussion of the problems of the moment and the immediate future. Further details will be announced in a subsequent issue of the *Journal*.

The Right Kind of Publicity

The Times Gazette is a newspaper which enjoys a wide circulation in the flourishing industrial cities of Oshawa and Whitby. Not long ago it published a twelve-page section entirely devoted to community health which is a model of its kind and that reflects great credit on all concerned. Every phase of health activity in which the local community is engaged received due consideration and not least among them was the Oshawa General Hospital and its School of Nursing. The superintendent of nurses, Miss Eugenie Stuart, utilized this valuable opportunity of recruiting student nurses by writing a delightfully imaginative forecast of the new and happier world that the students who enrol in 1944 will enter, as graduate nurses, in 1947. This sketch was so skilfully worded that it would appeal to parents as well as to the girls themselves. This is the sort of "good press" that nursing needs. There should be more of it.

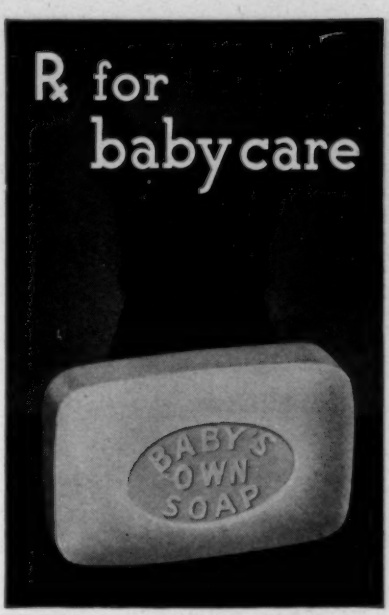
Victorian Order of Nurses

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Julia Meyer, a graduate of St. Mary's Hospital, Kitchener, has been appointed temporarily nurse-in-charge of the North Bay Branch.

Jean Malcomson, a graduate of the Toronto General Hospital, has been appointed temporarily to the St. Catharines staff.

Helen Kirk has resigned from the Sherbrooke staff and has accepted a position as



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public health nurse for the County of Middlesex.

Phyllis Hill has resigned from the East York staff and has entered the R.C.A.M.C. Nursing Service.

Margaret Hardy has been transferred from the Pictou Branch to the Hamilton Branch.

Mary Henderson has been transferred from the East York staff to take charge of the Waterloo Branch.

Ontario Public Health Service

Margaret Smith (Victoria Hospital, London, and University of Western Ontario public health nursing course) recently began her work as senior nurse with the recently established Middlesex County School Health Service. Her headquarters are in London. Miss Smith was formerly with the United Counties Board of Health, Morrisburg.

Helen Kirk, B.Sc. (University of Western Ontario public health nursing course) is on the staff of the Middlesex County Service. It is expected that two additional staff nurses will be appointed.

Phyllis Thomson (Harper Hospital, Detroit, and University of Western Ontario public health nursing course) has accepted the position of senior nurse with the newly organized Elgin County School Health Service. *Margaret MacNabb* and *Dorothy Hourd* (Victoria Hospital and University of Western Ontario public health nursing course) are associated with Miss Thomson, with headquarters in St. Thomas.

In the village of Leaside, adjacent to Toronto, a generalized public health nursing programme has been organized by the Board of Health. *Mrs. A. W. Jewell,* née Meagher (St. Michael's Hospital and University of Toronto public health nursing course) has been appointed senior nurse, with *Audrey Lamb* (University of Toronto public health nursing course) as assistant.

Rita Brooks (Royal Victoria Hospital; McGill University, public health; Teachers College, Columbia University, B.Sc.) has been appointed public health nurse in Orillia to succeed Phyllis Thomson.

Mrs. Ewart Bonter, née North (University

of Western Ontario public health nursing course) has been appointed by the Peel County School Medical Inspection Committee to carry out the school health programme there.

Geraldine Conley (Hospital for Sick Children and University of Toronto public health nursing course) has been appointed supervisor of nursing by the Kingston Board of Health. Miss Conley was formerly with the Peterborough Board of Health.

Mrs. Irene Gibson, née Vrooman (University of Toronto School of Nursing four-year course) has been appointed to the Peterborough Department of Health.

Mrs. Sara Reddon (University of Toronto public health nursing course) has retired following a number of successful years in public health nursing work in the Birchcliffe school area, Scarboro Township and the village of Leaside.

Shirley E. Allen (Victoria Hospital and University of Western Ontario) has joined the staff of the Oxford County School Health Service.

NEWS NOTES

ALBERTA

EDMONTON:

The annual meeting of the Royal Alexandra Hospital Alumnae Association was held recently, and the members gathered from the various reports that we have had a very successful year. The most important features were donations to the Aid to Russia Fund, the Navy League, and the Red Cross.

The following officers were elected for the coming year: honourary president, Miss M. S. Fraser; president, Miss V. Chapman; first vice-president, Miss A. Anderson; second vice-president, Miss A. Lysne; recording secretary, Mrs. Furier; corresponding secretary, Miss L. Thomas; treasurer, Miss D. Watt.

BRITISH COLUMBIA

Vancouver General Hospital:

The annual banquet of the Alumnae Association of the School of Nursing of the Vancouver General Hospital was held recently when the 1944 graduating class were entertained as guests. There was a large attendance and opportunity was afforded to greet the graduating class and to renew many old friendships. The president, Mrs. Logan Findlay, welcomed the graduating

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class and invited them to take an active part in the affairs of the Alumnae Association. An entertaining skit was presented by Mrs. F. Morgan and Miss Erma Erskine, and community singing, led by Miss Margaret Kerr, rounded out a very enjoyable evening. Miss M. Allport was the very able convener.

Miss Julia Walters, clinical instructor at the V.G.H., recently resigned to join the Royal Canadian Naval Nursing Service. Mrs. Pearl Needham (Pearl Ruthan), who was recently repatriated with the group on the S. S. Gripsholm, has returned to Australia and plans to join the Australian Military Nursing Service. Miss Janie E. Jamieson has been appointed provincial convener of the press and publications committee of the Registered Nurses Association of British Columbia.

MANITOBA

BRANDON:

At a recent meeting of the Brandon Graduate Nurses Association, Mrs. H. E. Hannah presided. Following the business session, the doctors' wives group took over. The guest speaker, Dr. S. J. S. Peirce, spoke on penicillin — its value and method of preparation. A social hour followed.

Miss Mabel Faust, who was recently appointed travelling instructor of nurses for Manitoba, was the guest speaker at a recent meeting of the Brandon Graduate Nurses Association held at the General Hospital. The president, Mrs. H. E. Hannah, introduced Miss Faust who told of the post-graduate courses now available to nurses in Canada. Members of the senior class of the School of Nursing of the Brandon General Hospital were special guests. The entertainment and program were in charge of the married nurses section.

NOVA SCOTIA

The Registered Nurses Association of Nova Scotia wishes to announce that a change in their office address from 413 Dennis Bldg. to 301 Barrington St., Halifax, took place on March 1.

A Nurses Placement Bureau was opened at this office on the same date under the direction of the present registrar, Miss Jean C. Dunning. Information regarding positions for nurses may be obtained from this office.

At a recent meeting of the Halifax Branch, R.N.A.N.S., Squadron Leader Stewart Thompson gave an illustrated lecture on plastic surgery A future meeting will deal with the subsidiary nurse.

Marjorie MacMahon and Beryl Hague, of the Children's Hospital staff, left recently to join the Armed Forces.

Halifax Infirmary:

The annual meeting of the Halifax Infirmary Alumnae Association was held recently with the president, Mrs. Gerald J. McKeown, in the chair. Reports were received from the various officers of the activities during the year. There was a decrease in the attendance due to the fact that some of the members have entered the Armed Forces and are now overseas. The following members are taking courses in public health: M. P. Smith, Toronto University; C. Gibson, Toronto University; R. Butler, Ottawa University; I. Shofer, McGill University.

The Alumnae Associaton suffered the loss of one of its most valued members, Ellen Chisholm, night supervisor at Camp Hill Hospital and, at the time of her death, vice-president of the Association.

During the year the members have worked in aid of the Red Cross and the Merchant Marine in hospital. At Christmas, the sick members were remembered by a year's subscription to *The Canadian Nurse*. In their note of thanks, they were most appreciative of the gift. Several new books have been added to the Library and each year a sum of money is voted by the Alumnae Association to purchase books. After each meeting during the year, a dainty lunch was served by the Sisters.

At this annual meeting, it was decided that the Alumnae Association would sponsor the Group Hospitalization Plan.

The following are the newly elected officers for 1944: president, Neva Harley; vice-president, Marcella Boyle; recording secretary, Katherine Duggan; corresponding secretary, Mrs. Lawrence O'Brien; treasurer Norah Thibodeau; convener of press committee, Mary West; convener of nominating committee, Colette MacDonald; library, Virginia MacDonald; entertainment, Viola Bown.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.

District 1

CHATHAM:

At a recent meeting of the Alumnae Association of the School of Nursing of the Public General Hospital the members pledged themselves to raise $500 to furnish the teach-

Compare your shoulders with your face. Isn't it true they look years younger? You see, shoulders stay smooth, soft, *elastic*—while faces have pores clogged with make-up, unable to breathe for hours at a time. And when pores can't breathe, skin becomes lifeless and prematurely aged. But this needn't happen to *your* complexion. Palmolive can keep *your* complexion young.

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ing unit in the new Priscilla Campbell nurses residence.

The president, Miss D. Hooper, was chosen to attend as a delegate to the meeting of District 1, R.N.A.O. to be held in London.

At the March meeting a cup and saucer shower is to be held. This equipment will be placed in the new cupboards, now being completed in a room at the hospital, so that after our meetings we may enjoy a social cup of tea.

Districts 2 and 3

Kitchener:

The regular monthly meeting of the Kitchener and Waterloo Chapter was held recently. Following the business meeting a talk given by Mrs. Irene Schnarr on beauty culture proved most interesting and was enjoyed very much. Miss Florence Weicker, the new president, presided.

The regular monthly meeting of the industrial nurses of Kitchener and Waterloo was held with Miss Grace Kaiser, chairman, presiding. A theatre party followed the meeting.

District 4

Hamilton:

The Hamilton General Hospital Alumnae Association recently held its first meeting of the year when the business session was followed by songs, dancing and recitation.

A new department recently opened at the H.G.H. is the central supply room, with Mrs. Nickling in charge. Edith Bingeman is now classroom instructress, taking the place of Henrietta Alderson who left recently to take a position in Brandon.

District 5

Toronto:

Hospital for Sick Children:

Many of our graduates are doing volunteer work at the blood clinics at the various centres in Toronto, Montreal, Vancouver and London.

Hazel Hughes has joined the Nursing Service of the R.C.A.F. Nora Crozier, Marjorie Adair, Jean McConnell, and Clara Morris are all with the R.C.A.M.C. Nursing Service overseas. Mary Ingham has accepted the position of assistant superintendent of nurses at the Western Hospital, Toronto. The following have been appointed to the Department of Public Health, Toronto: Marion Boaz, Ethelyn Jeffers, Nora Wickson. Reta Rutcliffe, formerly supervisor in the Hamilton General Hospital, is now public health nurse in Swansea. Edith Minty is public health nurse at Hespeler, Ontario. Doris Gowe is with the Red Cross Hospital at Dryden, Ontario. Elizabeth Edgerton has joined the orthopaedic unit in Scotland.

Toronto Western Hospital:

At a recent meeting of the Alumnae Association of the Toronto Western Hospital the guest speaker was Nursing Sister Catherine Christie, R.C.A.M.C., recently repatriated from Hong Kong where she had been a prisoner-of-war for two years. Miss Christie told of her trip to Hong Kong and gave vivid descriptions of the hospitals and

the population, and the spirit of the British and Canadian soldiers, and the air raid shelters provided. In spite of the inconveniences and anxieties endured during all this time Miss Christie's natural wit and humour enlivened her experiences, dating from the time of her departure from Toronto in December 1941 and ending with the thrilling experience of her home-coming.

Nursing Sister Grace Patterson (overseas) was awarded the Associate Royal Red Cross in the recent New Year Honours list. She is a graduate of the School of Nursing of the Toronto Western Hospital.

District 8

Ottawa Civic Hospital:

At the annual meeting of the Alumnae Association of the School of Nursing of the Ottawa Civic Hospital, Miss Emily Maxwell, O.B.E., matron of the nurses residence, was made an honourary member of the Association. The report of the activities of the past year, given by Miss Betty Serson, referred to many interesting events. Chief among them was the dinner given in honour of the 73 members of the Class of 1943, the largest ever to graduate from the School. The noted journalist, Mr. Austin Cross, was guest speaker on this happy occasion.

Among the speakers at the regular meetings were Mr. E. Hewitt, who gave an illustrated lecture on "Historic England"; Dr. Fisher, who discussed the newer drugs; and Dr. Victor Podoski, the Polish Minister to Canada, who spoke on "The Women of Poland". Miss Gerturde Ferguson summarized many interesting articles of various stimulating topics.

Contribution to the war effort included the purchase of three hundred dollar War Bonds, a rummage sale, and raffles, the proceeds from which were donated to war charities. Our nurses in Africa were remembered at Christmas and special parcels were sent to civilian nurses in England. The Vesper Service and the annual Maytime tea were well attended. Altogether, the year 1943 proved to be both enjoyable and sucessful for our Association.

District 10

The December meeting of District 10, R.N.A.O. was postponed until the first week in January on account of the prevailing epidemic of influenza. The annual reports were given by the chairmen of the sections and also the chairman of the District. Our guest speaker was Miss Jean C. Mason who has recently returned from the Hairmyres Orthopedic Hospital in Scotland, and has again

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Then, separate chapters are devoted to each category of surgery (i.e., throat and neck; chest; abdominal) and its operating room technique. For each is given anesthesia, position, preparation, draping, examination, instruments and equipment, followed by listed steps in surgical technique and their corresponding operating room procedures.

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R.N.A.P.Q. Scholarships 1944-1945

The Board of Management, **The Registered Nurses Association of the Province of Quebec,** is pleased to announce that two Scholarships will be awarded, covering $350 each, to English and French-speaking members in good standing in the Association who wish to follow postgraduate courses.

Application forms may be obtained at the office of the Association, **1012 Medical Arts Bldg., Montreal,** and must be returned completed before **June 1, 1944.**

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taken up her work at the Red Cross outpost at Kakabeka. The Hairmyres Orthopedic Hospital is of special interest to the members of this District because its matron, Miss Alice B. Hunter, was formerly assistant superintendent of the Port Arthur General Hospital, and always did all she could to make the meetings of the District interesting.

At a District meeting held on February 2, the program was arranged by Dr. W. G. Brown, medical officer of health for north-western Ontario, and was carried out by the nursing personnel of his office. Major John A. Leroux, R.C.A.M.C., who is in charge of venereal disease control in Ontario, was the guest speaker. He gave us a very comprehensive picture of the situation in Canada and on the completion of his address two educational films were shown. At the request of Dr. Brown invitations were extended to teachers and other groups of women who were interested in this problem. A short business meeting was held at the conclusion of the program at which the chairman gave a report of the board meeting of the R.N.A.O. held recently in Toronto.

The public health section of District 10, R.N.A.O. recently held their first meeting of the year in the Public Health Offices of Fort William. Last year this group made a study of industrial nursing and are now planning a program with health teaching as the subject. Dr. W.. G. Brown, D.P.H., medical officer of health for Fort William and north-western Ontario, gave an excellent introduction to health teaching in his address to the nurses.

QUEBEC

MONTREAL:

Montreal General Hospital:

At the February meeting of the Montreal General Hospital Alumnae Association we were honoured in having as a speaker, Acting Captain Agnes Tennant, who spoke of her work with the R.C.A.M.C. Nursing Service in England and also about her present duties in teaching nurses and orderlies at Camp Borden. Miss Tennant is a graduate of the Montreal General Hospital School for Nurses and of the McGill School for Graduate Nurses. Prior to joining the R.C.A.M.C. Nursing Service she was a medical supervisor at the M.G.H. Her address was thoroughly enjoyed and we all wish Captain Tennant continued success.

As everywhere, many of our nurses are joining His Majesty's Services — from the Central Division are M. Abbott, M. Harrison, H. Christian, I. Gibson, and J. Pugh, L. Ellard is now in charge of Ward L, R. Caldwell is in charge of Ward G. and Miss Chalmers is in charge of Ward F.

Royal Victoria Hospital:

Mary Quarmby is taking a postgraduate course at the New York Psychiatric Institute. Elsie Allder and Dorothy Goodill are

visiting Toronto and Ottawa hospitals. Muriel Stewart has joined the staff of the x-ray department. Clara Cook is now in charge of the 4th floor, Ross Pavilion, replacing Marion Barrett who has joined the R.C.A.M.C. Nursing Service Blaikie Smith has joined the Royal Canadian Naval Nursing Service and Elizabeth Manning, Elizabeth Cunningham, Betty Munro, Eleanor McNaughton, Lillian Donald, Rita Ferguson, Ruth Gray and Edith Pratt have joined the R.C.A.M.C. Nursing Service. Miss Hebb and Miss Strang, on the staff of the women's pavilion, have gone to Chicago for observation in the nurseries of the Michael Reese Hospital.

McGill School for Graduate Nurses:

Recent visitors and guest speakers at the School included Miss Ethel Johns, Miss Kathleen W. Ellis, Miss Maude H. Hall, acting chief superintendent of the Victorian Order of Nurses, and Miss Edna L. Moore, chief public health nurse, Ontario Department of Health.

Julia K. Walters (T. & S., 1942), formerly on the staff of the Vancouver General Hospital, is now serving with the Royal Canadian Naval Nursing Service. Margot P. Carson (T. & S., 1942), formerly on the staff of the Royal Columbian Hospital, New Westminster, is now serving with the Royal Canadian Naval Nursing Service.

SHERBROOKE:

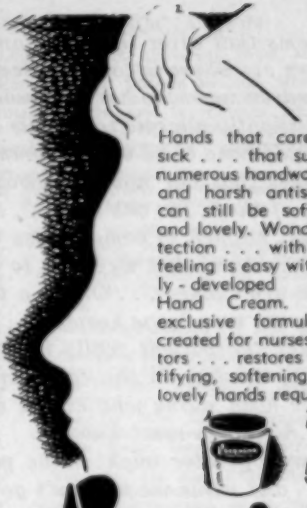
The Sherbrooke Hospital Alumnae Association recently held its annual meeting with Mrs. Howard Leslie, retiring president, in the chair. The annual reports given by Mrs. Gordon Sangster, secretary, and Mrs. Harry Grundy, treasurer, revealed that the past year had been a satisfactory one for the Association. During 1943 donations were given to the Red Cross, V.O.N., Russian Relief, and British Nurses Relief Fund.

The following officers were elected to serve during the coming year: honourary president, Olive Harvey; president, Mrs. E. Taylor; first vice-president, Mrs. Fred Simpson; second vice-president, Helen Dundin; recording secretary, Mrs. Gordon Sangster; corresponding secretary, Mrs. Gerald Osgood; social and entertainment, Mrs. D. Beaman; representatives to: private duty section, Mrs. Nelson Lothrop; *The Canadian Nurse*, Miss Katharine Vaughan.

We felt most keenly the absence at our annual meeting of our late hospital superintendent, Miss Verna Beane, whose death occurred last June.

Nursing Sisters Alfreda Dearden, Margaret Gelinas, Ellen Thorburn, and Dorothy Kerridge are serving with the R.C.A.M.C. Nursing Service and Nursing Sisters Norma Beattie and Mary Giroux are with the R.C.A.F. Nursing Service.

NURSES



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It seems that after the war Canada is to have its own civilian Order of Chivalry . . . There is to be a "Canada Medal" . . . that will be bestowed on men and women who have served their country faithfully and well . . . Although slightly allergic to medals . . . we think this is a grand idea . . . but we would hate to be on the committee of selection . . . because we feel in our bones that our nominees wouldn't have a ghost of a chance . . . Too many of them, for one thing . . . and we don't even know their names . . . we just happen to come across them, time and again, when we least expect it . . . Now that we come to think of it . . . most of the potential candidates are women . . . One is a telephone operator and runs a switchboard in a not very large hospital . . . She will take endless trouble to find out whether the patient really had a good night . . . and if she detects a quaver of anxiety in the enquirer's voice . . . will try to track down the elusive head nurse who knows all about it . . . A famous columnist . . . (F.P.A. if you must know) . . . once said that a competent hospital switchboard operator ought to be paid more than the superintendent of nurses . . . and while we wouldn't go quite that far . . . we do think she is public relations officer number one . . . Another woman we have our eye on . . . is a waitress in a department store restaurant that caters to elderly customers . . . The way this girl manages cranky and demanding old ladies is a joy to behold . . . She likes doing it too . . . and takes pride in getting cross old Mrs. Jones off to a happy start on the forty-eight cent early shoppers lunch . . . by making sure that the plate is hot, the fish has a fresh sprig of parsley on it, and the coffee hasn't slopped over into the saucer . . . we could use some of this psychological approach to good effect in the nursing world and it might be a good idea to have groups of student nurses brought in for a sort of bedside clinic . . . Just to show that we have no prejudice against the sterner sex . . . we now nominate a minor official who gives out information about trains in one of our great metropolitan stations . . . (no, we can't tell you which one) . . . Protected from the onslaught of the impatient travelling public by a circular counter . . . he moves along the line clockwise with strict impartiality . . . and manages to make a timetable intelligible to the meanest intelligence . . . He is amazingly patient with Service men . . . and the other day we watched him plot out an itinerary for a bewildered soldier that saved six hours of a precious embarkation leave . . . He has a neat way of circumventing gate-crashers . . . no matter how well dressed they may be they just wait their turn . . . while he makes sure that a sailor who is a bit under the weather . . . gets on the right train for an Eastern Canadian seaport where a ship appears to be expecting him . . . Perhaps medals wouldn't appeal to any of these people . . . but, whether they know it or not, they deserve one. — **E. J.**

Official Directory

International Council of Nurses

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Numerals indicate office held: (1) President, Provincial Nurses Association; (2) Chairman, Hospital and School of Nursing Section; (3) Chairman, Public Health Section; (4) Chairman, General Nursing Section.

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Ontario: (1) Miss Mildred I. Walker, Institute of Public Health, London; (2) Miss Dora Arnold, Brantford General Hospital; (3) Miss Winnifred Ashplant, 807 Waterloo St., London; (4) Miss Stella Murray, Niagara-on-the-Lake.

Prince Edward Island: (1) Miss K. MacLennan, Provincial Sanatorium, Charlottetown; (2) Miss Anna Bennett, P.E.I. Hospital, Charlottetown; (3) Miss Ruth Ross, Summerside; (4) Miss Dorothy Greenan, 15 Grafton St., Charlottetown.

Quebec: (1) Miss Eileen Flanagan, 3801 University St., Montreal; (2) Rev. Soeur Décary, Notre Dame Hospital, Montreal; (3) Mlle Marie Cantin, 4352 St. Denis St., Apt 3, Montreal; (4) Miss Effie Killins, 3533 University St., Montreal.

Saskatchewan: (1) Miss M. R. Diedericha, Grey Nuns' Hospital, Regina; (2) Miss Ethel James, Saskatoon City Hospital; (3) Miss Mary E. Brown, 5 Bellevue Annex, Regina; (4) Miss M. R. Chisholm, 805-7th Ave. N., Saskatoon.

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Provincial Associations of Registered Nurses

ALBERTA

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Ponoka District, No. 2, Alberta Association of Registered Nurses

Chairman, Miss Mildred Nelson; Vice-Chairman, Miss Muriel Fuller; Secretary-Treasurer, Miss Ruth Parfett, Provincial Mental Hospital, Ponoka; *Representative* to *The Canadian Nurse*, Miss Frances Leek.

Calgary District, No. 3, Alberta Association of Registered Nurses

Chairman, Miss Kathleen Connor, Central Alberta Sanatorium; Vice-Chairman, Miss M. Deane-Freeman; Secretary, Miss Louise Thorne, 2208-50th Ave. S. E.; Treasurer, Miss Mary Watt; *Conveners of Sections*: *Hospital & School of Nursing*, Miss J. Connal; *Public Health*, Miss M. Pinchbeck; *General Nursing*, Miss G. Thorne.

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BRITISH COLUMBIA

Registered Nurses Association of British Columbia

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New Westminster Chapter, Registered Nurses Association of British Columbia

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Vancouver Island District

Victoria Chapter, Registered Nurses Association of British Columbia

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Prince Edward Island Registered Nurses Association

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QUEBEC

Registered Nurses Association of the Province of Quebec (Incorporated, 1920)

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SASKATCHEWAN

Saskatchewan Registered Nurses Association (Incorporated 1917)

Pres., Miss M. R. Diederichs, Grey Nuns' Hospital, Regina; First Vice-Pres., Mrs. D. Harrison, 301 Bottomley Ave., Saskatoon; Sec. Vice-Pres., Rev. Sister Mandin, St. Paul's Hospital, Saskatoon; *Councillors*: Rev. Sister Perpetua, St. Elizabeth's Hospital, Humboldt; Rev. Sister Irene, Holy Family Hospital, Prince Albert; *Chairmen of Sections*: *Hospital & School of Nursing*, Miss E. James, Saskatoon City Hospital; *Public Health*, Miss M. E. Brown, 5 Bellevue Annex, Regina; *General Nursing*, Miss M. R. Chisholm, 805-7th Ave. N., Saskatoon; Acting Secretary-Registrar, Mrs. Margaret E. MacLean, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

Regina Registered Nurses Association

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Alumnae Associations

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A.A., Misericordia Hospital, Edmonton

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A.A., Royal Alexandra Hospital, Edmonton

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BRITISH COLUMBIA

A.A., St. Paul's Hospital, Vancouver

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MANITOBA

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A.A., Children's Hospital, Winnipeg

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A.A., Winnipeg General Hospital, Winnipeg

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A.A., Brantford General Hospital, Brantford

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A.A., Ottawa Civic Hospital, Ottawa

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A.A., Ottawa General Hospital, Ottawa

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A.A., St. Thomas Memorial Hospital, St. Thomas

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